A FAIR START IN LIFE—*Every child has the right to be well born and to be protected with special care during the first year of life. These are responsibilities primarily of the parents, the family doctor, and the community. The educational and health agencies of the state and nation must help parents make intelligent use of the available health resources.*

Photograph by
H. Armstrong Roberts, Philadelphia

HEALTH in SCHOOLS

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TWENTIETH YEARBOOK

Copyright, February 1942

AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS
A DEPARTMENT OF THE NATIONAL EDUCATION ASSOCIATION OF THE UNITED STATES
(formerly the Department of Superintendence)
1201 Sixteenth Street, Northwest, Washington, D. C.

PRICE $2 00

AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS

Commission on Health in Schools

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Foreword

A sound mind in a sound body is a short but full description of a happy state in this world.—John Locke.

THUS IN HIS BOOK *Some Thoughts Concerning Education* John Locke has expressed the primary purpose of health education. For as Locke continues, "He that has these two has little more to wish for; and he that wants either of them will be little the better for anything else." Not only is health the basis of the individual's well-being but, as Disraeli remarked, it is the foundation of the people's powers as a state.

For several years within the Association there has been a demand for a statement of the administrator's role in a school program of health education. The Executive Committee authorized a yearbook on this topic in 1939. President Ben G. Graham appointed the members of the Commission. At the first meeting in Pittsburgh, May 1940, the Commission outlined its general plans and initiated its program of work. Thru conferences and correspondence, but particularly thru the efforts of its individual members, the Commission moved toward the completion of the present volume. Manuscripts were reviewed and revised several times. On no issue was the Commission ever seriously divided, and the present report represents the point of view of the Commission as a whole.

In presenting this volume the Commission is aware that it will be compared with other publications on the same general subject. One of the most important and useful of these is *Health Education,* prepared by the Joint Committee on Health Problems in Education of the American Medical Association and the National Education Association. *Health Education* and the present yearbook are complementary publications. The first is designed primarily for classroom teachers and for teacher-training supervisors; this yearbook will be most useful to school administrators. There are also numerous publications issued by the federal government and by individuals thru various well-known publishers. Many of these books and bulletins will be found listed on pages 353-63 of this yearbook. In purpose and in content most of these materials are designed to further the same educational objectives and for that reason will find a welcome place in many professional libraries.

The Commission is aware of the presentday interest in health and has given what it considered to be a reasonable amount of space to current problems. It would have seemed wise to some if the yearbook had devoted itself exclusively to a single subject such as nutrition or remedial work. Some may expect to find in the following pages "scarehead" titles urging social action to overcome the defects revealed by the Selective Service Act. Those who look for extreme positions and bizarre statements will be disappointed. The view of education is a long-time view; the health of the nation will not be permanently or constructively influenced by the technics of propaganda or by spasmodic campaigns.

Health has long been an aim of education. Presentday conditions require *intensification* of educational efforts because "gold that buys health can never be ill spent." Altho the yearbook points no moral or draws no conclusions (labeled as such), several lines of possible action appear from a reading of the chapters: (a) that more careful attention to a study of individual nature and health needs is needed; (b) that more effective machinery should be developed to eliminate physical and mental defects; (c) that the school program and its organization must be studied to eliminate the unnecessary tensions and strains harmful to both pupil and teacher health; and (d) that the possibilities of cooperative action in creating a healthful community should be explored under the leadership of educators. These are not the only roads to immediate action, but they suggest some of the types of activities that will concern school administrators.

In the preparation of a yearbook of this type the Commission must necessarily draw upon the work and publications of others. Most of the debt to these other sources is indicated in footnotes. Photographs were in some instances supplied by school systems. The Commission is genuinely grateful to all who have helped. Special acknowledgment is made to the staff in Washington for its share in the production of the volume. S. D. Shankland, executive secretary of the American Association of School Administrators, handled the business affairs of the Commission and participated helpfully in all deliberations. Frank W. Hubbard, director of research of the National Education Association, served as coordinator and edited the yearbook for publication. He was ably assisted by Beryl Evans and Josephine Sullivan of the Research Division and Marjorie Starr of the Division of Publications.

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THE EDUCATED PERSON—

¶ understands the basic facts concerning health and disease.

¶ protects his own health and that of his dependents.

¶ works to improve the health of the community.

—*The Purposes of Education in American Democracy*
Educational Policies Commission.

CHAPTER I

A Point of View on Health Education

OUR NATION WAS CREATED BY PEOPLE who hoped for freedom of thought and for an opportunity to achieve. Our government was established in the hope that homely virtues might endure, that men might live together peacefully, with liberty and justice for all. From the beginning, a democratic way of life had to be learned. The people had to devise new governmental forms and to invent new safeguards for the rights of man because a government almost without precedent was being established. Each individual had to learn new ways for himself. The democratic government which the people created required them to substitute self-discipline for the tyranny under which they had previously lived. Their children had to be trained for a new way of life and to help create that life.

As was natural, the schools were called upon to play a part. At first the school's role was small, but it has grown much greater as other methods for attaining the democratic ideal have failed. It has finally been recognized that the responsibilities of the school include far more than the mere teaching of subjectmatter. The child must be prepared for his life in a democracy. He must be taught to develop a healthy body, an educated mind, and a self-disciplined, self-reliant, socially-minded personality. In brief, he must be helped to adjust happily and successfully to the American pattern of living.

Health—A Continuing National Problem

The nation's health is measured primarily by mortality statistics. The United States has little in the way of accurate morbidity statistics. On the basis of official figures published by the United States Bureau of the Census, there can be no doubt that the nation's health has been steadily improving, but on the basis of these same rates it is equally certain that there is room for more improvement.

The death-rate from all causes was 13.6 per 1000 of estimated population in 1915 and 10.6 in 1939. There have been marked changes for the better in infant mortality rates and death-rates from the communicable diseases, especially tuberculosis, typhoid, diarrheal diseases of infancy, diphtheria, and scarlet fever. The life expectancy at birth, otherwise known as the average length of life, increased from approximately fifty-five years in 1915 to an average of sixty-one years in 1941. The infant mortality rate, which exceeded 150 in many communities in 1915 and now exceeds 50 only in relatively unfavorable areas, has dropped below 30 in many and below 20 in some—all on the basis of 1000 living births.

In the recent annual reports of the surgeon general of the United States Public Health Service appear the following quotations:

> A comparison of the present gross and specific death rates with those of a few years ago indicates that public health workers have reason to congratulate themselves on what has been achieved. More than three-quarters of a million lives were saved in the United States in 1936 as compared with the number of deaths that would have occurred had the death rate remained the same as in 1900 (1938 Report.)
>
> An appreciable decline in the general death rate for the United States was indicated by the provisional rate of 10.6 per 1,000 population for 1938 as compared to the final rate of 11 2 for 1937 This is the lowest rate since the death registration area was established by the United States Bureau of the Census in 1900. (1939 Report.)
>
> Health conditions remained generally favorable throughout the nation during the calendar year 1939. (1940 Report.)

On the less favorable side we find steady increases in deaths from heart disease, cancer, brain stroke, diabetes, and other diseases incident to middle and old age. Motor vehicle accidents (except among school children) and accidents in the home have increased, while industrial accidents have declined sharply in response to safety education programs. At the same time, it is estimated that large numbers of persons at all ages are inadequately nourished and it is certain that many have uncorrected physical defects, unsatisfactory health habits, and faulty mental hygiene.

The draft rejections have been cited as an index to the nation's health.[1] It has been claimed that the large proportions of rejections in 1940 as compared with 1917 were an evidence of deterioration in health and physical fitness of the nation. As a matter of fact, the

---

[1] Interpretations of the selective service and Army health statistics are to be found in June 1941 issue of *Michigan Public Health*, "Physical Fitness of Draftees" (November 1940) and "Physical Fitness of American Youth" (June 1941), *Statistical Bulletin*, Metropolitan Life Insurance Co., "Health of Army Better Than in First World War," Medical Preparedness Section, *Journal of the American Medical Association*, October 11, 1941, and Uhler, William P "Draftee Rejections Have Implications for School Health Programs" *American School Board Journal* 103· 27-28, October 1941

1917 and 1940 draft figures are not directly comparable for many reasons. The Army standards have been raised since 1917; medical knowledge has advanced and diagnostic methods are more effective; draft selections in 1940 were being made with more deliberation and more thoroness than in 1917. The examination for the Army is specialized. Many men who are rejected for military service are fit for peace-time jobs and are as healthy as men who are taken into the Army. The rejection rate for the Army is far higher than for life insurance. America's youth today is more fit to serve the country than was any previous generation including the youth of the First World War period. America's new Army is in better physical shape than the forces of 1917-18.

The health of the nation has not reached an ideal status or even a satisfactory status; it nevertheless is no cause for despair. It is neither as good as it could be nor as bad as it might be and it is constantly improving. The opportunity for improvement constitutes a challenge to the schools and an obligation to evaluate their present contributions with a view to improvement.

The school is not the sole agency responsible for the health of the people. The health of the people is determined by many factors, including heredity, home environment, nutrition, personal attitudes, intelligence, information, economic status, accidents, disease, or injury. It would be as unfair to attribute ill health in the nation to failure of the schools as it would be unwarranted to claim all health progress as caused solely by the schools. Yet the schools are a vital factor. In the school is offered unparalleled opportunity for acquiring health knowledge, forming health attitudes, and establishing health practices. Ignorance about health remains widespread, even among otherwise well-informed and well-educated persons. Superstition and misinformation are by no means confined to the illiterate or those with limited education.

Health—A Continuing Educational Problem

In the health program of the modern school in a democracy there are six basic areas of responsibility. (Here they are merely listed. The remainder of this volume is concerned principally with the part played by the school administrator in making them effective.)

1. *A healthful environment must be provided*—Such an environment is essential in any functioning health program. Creating it involves such things as the health of teachers, the control of communicable diseases, the elimination of the causes of accidents, the avoidance of conditions harmful to health, and the use of teaching methods which are effective without causing worry or fear. The public school has a unique position among the agencies interested in the welfare of children and from it should come the initiative for coordinating all the community resources. Thru its leadership not only the school but also the homes and the entire community can be made safe for all the children.

2. *A health guidance program is essential*—Day-by-day observations by the teachers, periodic health examinations, and health histories are necessary to discover children who have conditions which are detrimental to themselves or others. Whenever such conditions are found, appropriate steps must be taken to eliminate them.

3. *Emergency health conditions demand immediate care*—No matter how healthful the school environment may be, some illness is certain to develop and some accidents to happen. Both the pupils and the school staff must be prepared to care for such emergencies. The teachers need to be on the alert for symptoms of acute conditions. They should recognize them and should know the proper procedures to follow. They must have the authority to do whatever is necessary to protect both the ill child and his classmates.

The children themselves ought to know the procedures to follow in case of accident or illness. Otherwise, by their attempts to be helpful, they may aggravate a bad condition and cause needless suffering.

It is part of the school health program to formulate the procedures to be used in emergencies, to instruct the pupils and teachers concerning them, and to make them effective when emergencies do arise.

4. *Accurate health information should be taught*—The child needs to know a great deal about health, and it is a responsibility of the school to instruct him. For example, he needs to know how to develop good health for himself, how to avoid illness and accidents, and how to protect the health of others. Similarly, he must understand such things as the difference between an adequate and an

inadequate diet, the effect of drugs and stimulants, and the value of vaccination and immunization.

Unfortunately, the child is constantly receiving much misinformation by means of the radio, newspapers, and magazines. He is being misled by superstitions, sales talk, and faddists. His best hope of finding the truth is thru his school.

5. *Sound health habits and attitudes need to be established*—Besides knowing what things are good for one's health, a person needs to establish sound health habits. It is only by the practical, habitual use of one's knowledge that both physical and mental health will be maintained. The program of the school is designed to develop habits such as cleanliness, proper eating, regular elimination, recreation, adequate exercise and rest, and the practice of seeking medical advice when needed. The school's efforts are effective to the extent to which desirable habits and attitudes are carried over from the school into daily life.

6. *The exceptional child requires a modified school program*—In order to achieve the aims of a democracy, it has been necessary to educate children in groups. For some exceptional pupils the regular program must be varied. This is particularly true for children who are ill or crippled or who do not see or hear normally. The health program includes the special care that is needed to give these children an educational opportunity comparable with that of normal children.

Whether or not these health responsibilities of the school will be faced depends first of all upon administrative leadership. It is the responsibility of the school administrator to stimulate the formulation of policies and to translate those policies into working procedures. To a large extent, health in the school, in the home, and in the whole community depends upon his vision.

CHAPTER II

Organization and Administration of the General Program

As in any other phase of schoolwork the primary responsibility for the successful functioning of the school health program must rest on the administrator. How to meet this responsibility most effectively should be the concern of every school administrator, and no satisfactory results should be expected unless he accepts this responsibility with sympathy, intelligence, and forceful leadership. When failure has occurred it has usually been due to this lack of leadership.

If the administrator comprehends the meaning of health and its relationship to the educational process and has a clear concept of the major objectives and the more immediate aims in the functioning of the school, he has taken the first step in meeting his responsibility in health education and in the assurance of a successfully functioning program.

Health: A Vital Factor in Life and in Education

Since to the school is assigned a large part in the educative process, particularly in the formative years of childhood and youth, education in health becomes a direct responsibility of the school. The White House Conference report of 1930 sets forth this fact clearly in the following words, "The school program must be arranged to protect and improve the physical, mental, and emotional health of every child and to preserve that most sacred thing to every child—his personality—and allow him the fullest opportunity to develop his best self." [1]

Many similar pronouncements have been made in recent years by eminent authorities in the field of education and by members of the medical profession who are deeply concerned with the present and future health of the nation and the race. That "education for healthful living should be one of the main objectives of any school system" is now generally accepted. Still, confusion exists because of a lack of clear concepts of health and a lack of clarity as to the aims of health education.

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[1] White House Conference on Child Health and Protection. *Addresses and Abstracts of Committee Reports.* New York, Century Co., 1931 p. 170.

Health has been defined by Jesse F. Williams as "the quality of life that renders the individual fit to live most and to serve best."[2] This is a broad but nevertheless true interpretation of health, something more than the physical well-being due to absence of disease or defects in the smooth performance of the bodily functions. Of course, physical health is fundamental but there exists also the need of emotional stability and social adaptability. It is the ability to meet "the crises of life in such a way that distinct advance has been made for the individual or for society or both." The ultimate criterion of health is conduct.

Health education as applied to the school thus resolves itself into creating and maintaining those conditions, experiences, and opportunities that will enable each individual connected with the school to do his best work with maximum satisfaction and enjoyment to himself and to society during both school and post-school life.

As for the aims in health education, no better presentation has been made than that given by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association:

> 1. To instruct children and youth so that they may conserve and improve their own health.
>
> 2. To establish in them the habits and principles of living which thruout their school life and in later years will aid in providing that abundant vigor and vitality which are a foundation for the greatest possible happiness and service in personal, family, and community life.
>
> 3. To promote satisfactory habits and attitudes among parents and adults thru parent and adult education and thru the health education program for children, so that the school may become an effective agency for the advancement of the social aspects of health education in the family and in the community as well as in the school itself.
>
> 4. To improve the individual and community life of the future; to insure a better second generation, and a still better third generation; to build a healthier and fitter nation and race[3]

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[2] Williams, Jesse F *Personal Hygiene Applied.* Philadelphia W. B. Saunders Co., 1941. p. 2.

[3] National Education Association and American Medical Association, Joint Committee on Health Problems in Education *Health Education.* Washington, D C · the National Education Association, 1941 p. 15.

Practically speaking, then, health education calls for such studies and activities, together with such environmental conditions, as will make possible an optimum realization of these aims. To meet this responsibility fully the school must have a definite, adequate, and successfully functioning program in health education which influences every condition, situation, and experience in the operation of the schools whether in the classroom, auditorium, shop, laboratory, or playground. It must extend its influence to the out-of-school and post-school life of the children and it would be well if it included their preschool years This program must be built on sound educational philosophy and practice, giving due consideration to the needs, aptitudes, and capacity of each individual.

The planning of the program must be fully comprehensive in scope and practicable in its application. There is today an abundance of authoritative material and approved activities; therefore, it is mainly a problem of selection and organization of content and its incorporation in the work and life of the school. The test of administrative ability lies in the wisdom of selection and skill in adjustment, followed by effectiveness in operation.

The school health program is made up of several components, each with its own distinctive purpose but at the same time so interwoven with the others that no one can function completely by itself while all have the same ultimate objective—health. To achieve the most satisfactory results all phases of the health program must be included and coordinated. For example, there is that section which introduces the doctors, nurses, and other specialists. Its work is based strictly on the knowledge and skill of the medical and dental professions. Yet these workers are never to achieve the results sought unless the principals and classroom teachers as well as the custodial and janitorial staff add their intelligent, wholehearted effort.

The health aspects of the physical education program require the participation and active support of physicians. Pupils with irregularities must be referred to the medical staff for guidance or instruction. Then again, principals, teachers, and others must cooperate in carrying out the program and in some levels carry on the work directly. The same rule applies in health instruction. In meeting this problem of general school hygiene every staff member must make his or her contribution. Distinct separation of these components can-

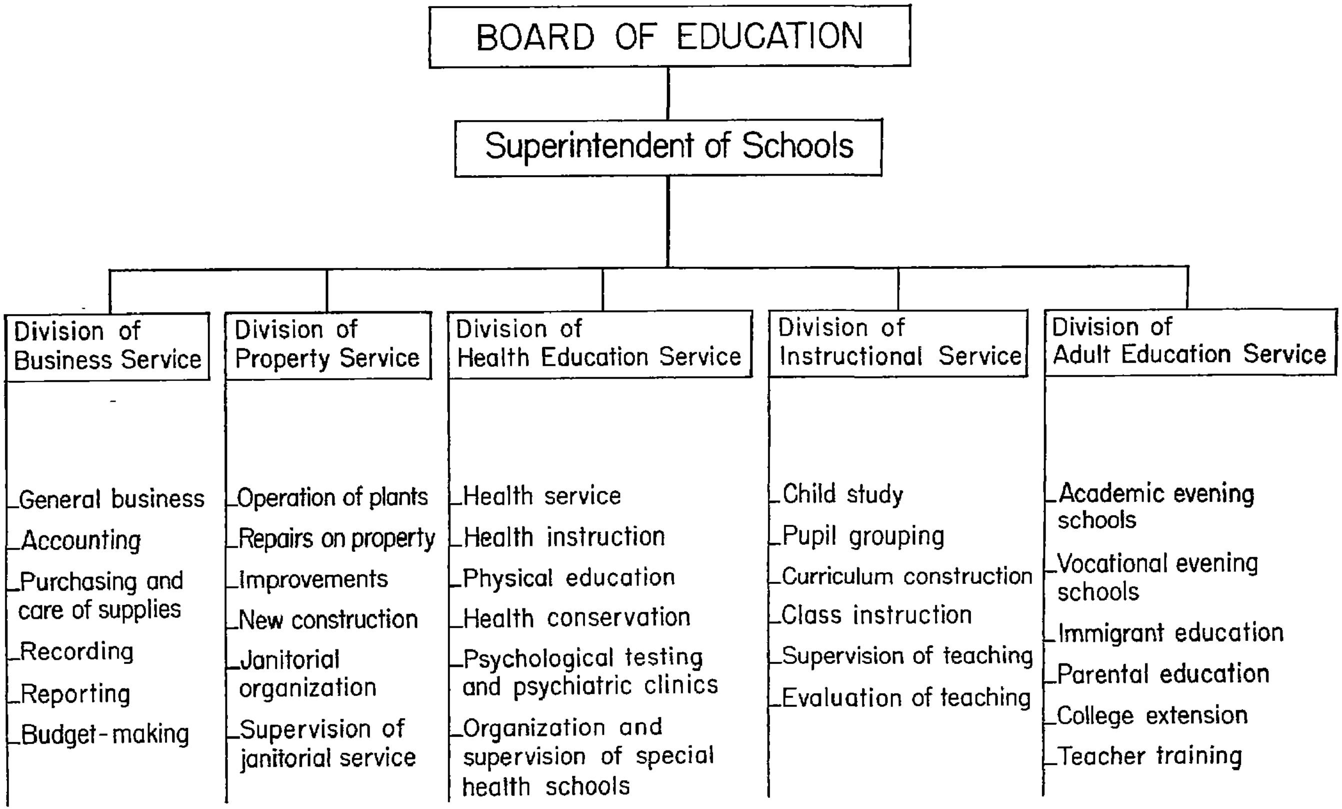


FIGURE I.—BINGHAMTON (NEW YORK) PLAN

not be made without devitalizing each component, thereby weakening the complete program. Well-planned coordination to secure mutual support and harmony in action is essential.

To assure harmony in action with maximum efficiency there must be unit direction or control by the administrator, either directly by the superintendent or someone designated by him as assistant superintendent, director, or coordinator. One possible administrative organization is that of Binghamton, New York, shown in Figure I. This plan is unique in that the health education service is coordinate with such other services as business management, instruction, and adult education. Under such an arrangement the possibility of the coordination of all personnel and activities designed to promote health is increased. In rural areas an administrative setup similar to Figure II may be followed for a county school system. In this plan various phases of the school health program are allotted to the various divisions which are assisted by specialists from the state government. Figure III shows a plan that may be used in a large city supplemented in this instance by local health and welfare agencies. In this yearbook these cooperative relationships are discussed in Chapter XV.

General Outline of the Health Program

The several components of the health program may be enumerated and briefly described as follows. Details will be given in subsequent chapters.

Health Guidance and Protection

For the phase of the program designated as "health guidance and protection" there is some difficulty in securing the right title. It is sometimes designated as medical inspection which is obviously a misnomer according to the presentday practice; it is also called medical service which is misleading. There exist different viewpoints as to the administration of health and medical services apart from health instruction in the schools. There are those who believe that school health work should emphasize the discovery and correction of defects as a function of the school itself extending full corrective measures as a public service to all school children. Others believe that this health service is a fundamental factor in education and should be approached from the standpoint of its educational possibilities. Physicians engaged in full-time schoolwork, or connected with

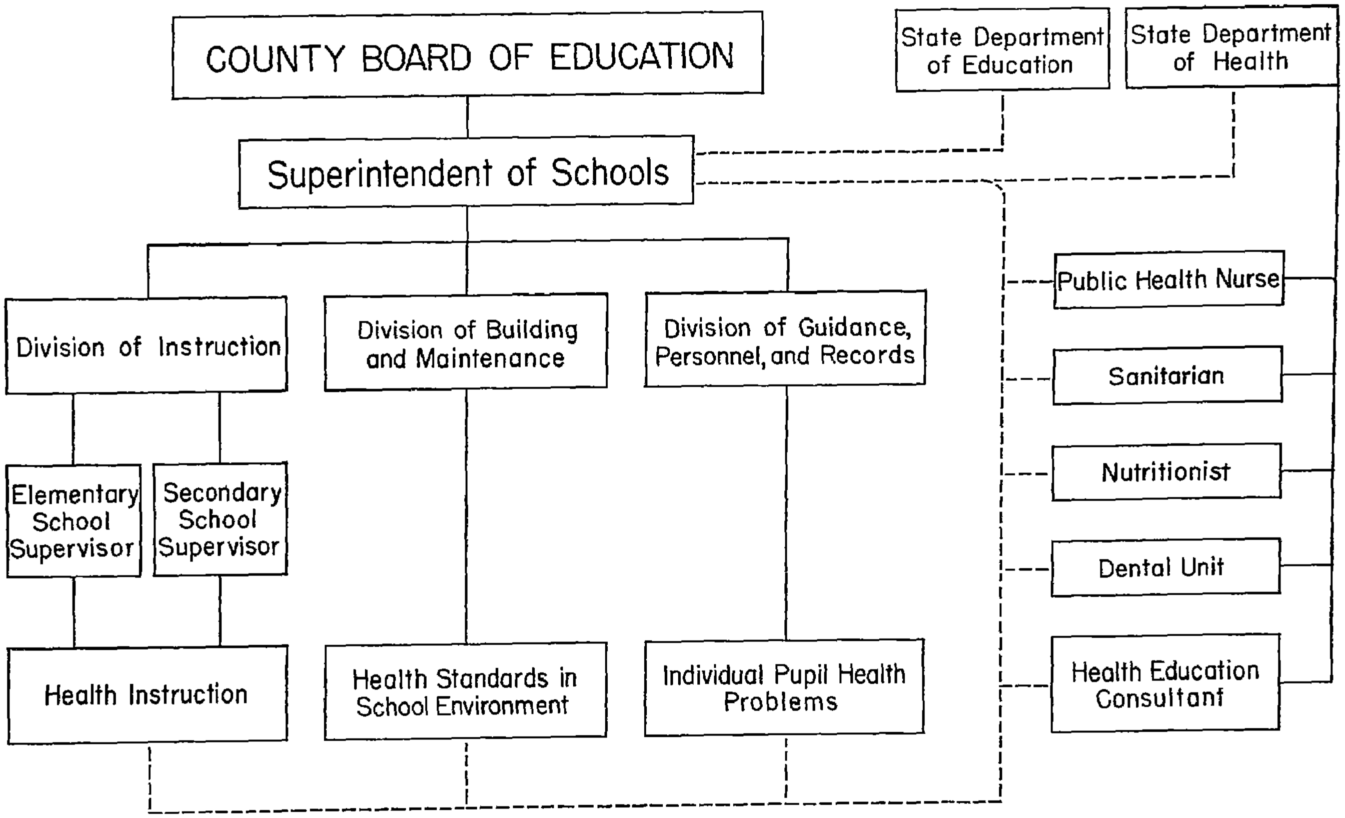

COUNTY BOARD OF EDUCATION
State Department of Education
State Department of Health
Superintendent of Schools
Division of Instruction
Division of Building and Maintenance
Division of Guidance, Personnel, and Records
Elementary School Supervisor
Secondary School Supervisor
Health Instruction
Health Standards in School Environment
Individual Pupil Health Problems
Public Health Nurse
Sanitarian
Nutritionist
Dental Unit
Health Education Consultant

FIGURE II.—COUNTY PLAN IN UTAH

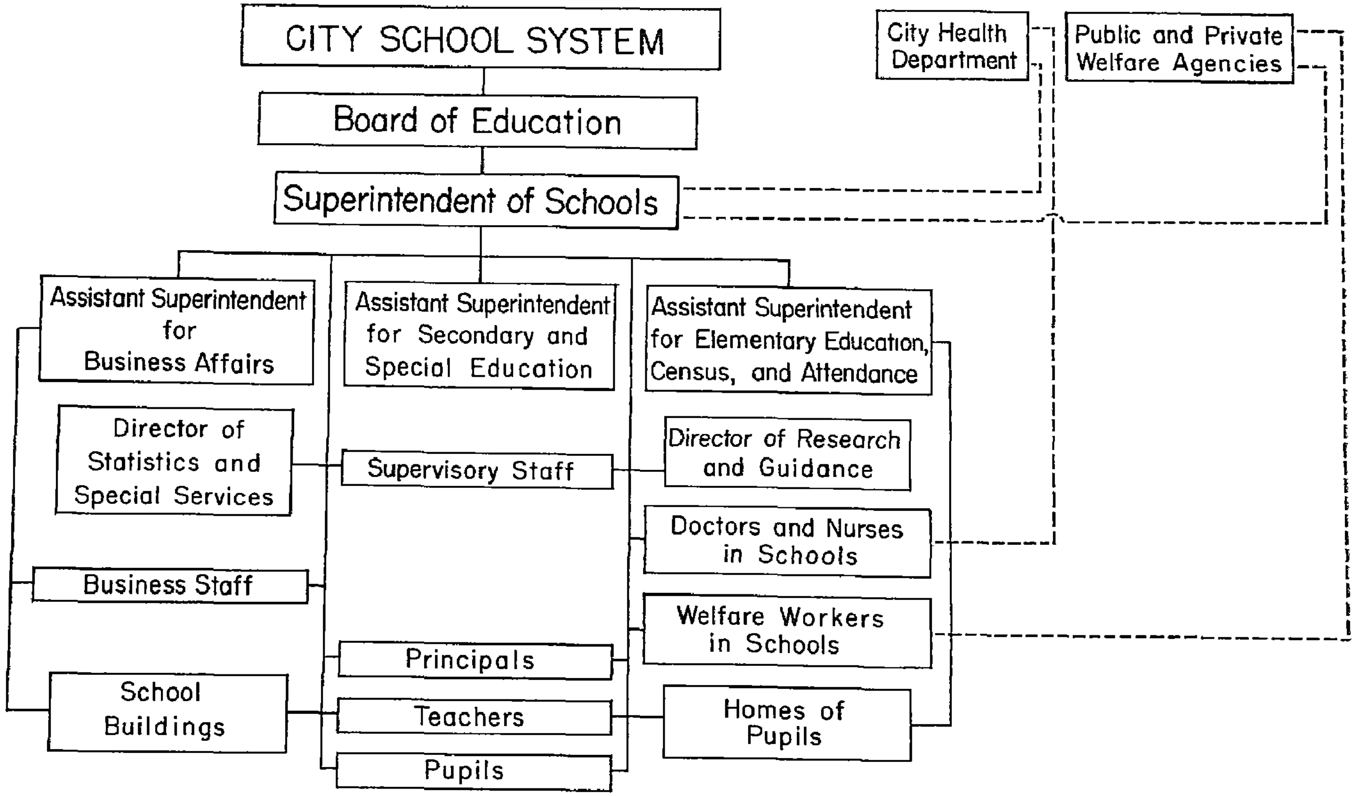

CITY SCHOOL SYSTEM
Board of Education
Superintendent of Schools
City Health Department
Public and Private Welfare Agencies
Assistant Superintendent for Business Affairs
Assistant Superintendent for Secondary and Special Education
Assistant Superintendent for Elementary Education, Census, and Attendance
Director of Statistics and Special Services
Supervisory Staff
Director of Research and Guidance
Doctors and Nurses in Schools
Business Staff
Welfare Workers in Schools
Principals
School Buildings
Teachers
Homes of Pupils
Pupils

FIGURE III.—ATLANTA (GEORGIA) PLAN

departments of health, may incline to the former view. Physicians in general practice are generally in accord with the latter view. The following presentation is in accord with prevailing educational thought.

Thru the work of the health staff, which may include doctors, nurses, dentists, psychiatrists, and other related specialists, children are examined, followed up, and protected thru hygienic safeguards.

The examination should be provided as often as necessary and should be as complete as the situation demands. The examination should inquire into the status of the whole child. Physicians will detect defects; but they should appraise attitudes, personality traits, and responses, as well as organic disturbances. An important part of child guidance begins in the health examination. Physicians should arouse in children motives of effort, cooperation, and personal support for improvement. In short, the examination is an educational experience of great import. More than arches are involved in a case of flat feet, and children are more than biological specimens, with or without tonsils (see Chapter III).

School physicians should possess the natural aptitudes and special training for this form of service. School nurses are essential staff members and should also be trained. School dentists and oral hygienists, when employed, may be important personnel and should thoroly understand their functions. Psychologists and psychiatrists are not only valuable aids but are quite necessary (see Chapter XIII).

The classroom teacher is strategically placed to aid in this service to children. Her observation of changes in children whom she sees every day and her alert recognition of signs and symptoms of health disturbances are vital in control of communicable disease and in early detection of abnormality. In the professional preparation of the classroom teacher, adequate instruction in her role in this program should be given.

Health Instruction

Health instruction means teaching children in the classrooms and in all situations in the school, both by direct and by incidental methods, so that each child may learn, for example, the scientific basis for correct living as related to nutrition, clothing, exercise, rest, cleanliness, immunization, first aid, safety, sanitation, and desirable social relationships. At the same time, there should be developed those habits and attitudes that lead to a consistent practice. The work in this field should be graded, organized, and applied in accordance with the same principles and procedures as those used in any other part of the school program. Chapters IV and V deal particularly with health instruction.

Trained specialists are necessary for supervision and for at least some of the instruction. In the elementary grades, most of the teaching must be done by the classroom teacher. On the secondary level, the direct teaching should be done by specially trained teachers, while incidental teaching should be the concern of every teacher. A specially qualified person is essential to coordinate these efforts.

Special Provisions

Special service is required for those exceptional children who are so handicapped, physically or otherwise, as to make it impossible for them to participate fully in the regular school program. Adapted programs may be used for some individual cases; with others, enrolment in special classes or schools is necessary. Orthopedic, sight, hearing, speech, cardiac, pulmonary, nutritional, and many other defects are included in these areas. Regular class and school environment is always to be preferred when possible.

Physical Education and Recreation

There is some difference of opinion as to whether physical education should be organized as a separate division in the school curriculum or whether it should be an integral part of the school health program. Regardless of the point of view, it must be recognized that physical education makes a distinct contribution to physical, mental, emotional, and social health, and must be included in a consideration of the school health program

By the most approved methods, thru instruction and training, the human organism should be developed as harmoniously and completely as possible. Thru the daily use of activities, such as individual exercises, rhythmic activities, games, gymnastics, athletics, and hiking, physical and social fitness must be established and maintained.

Specific teaching and practice for body control, power, agility, and endurance must be provided. There must also be provided specific teaching and practice in group activities to develop courage, initiative, self-discipline, cooperation, and loyalty.

This program has a fourfold function as follows:

1. To develop bodily efficiency
2. To teach serviceable skills that function in leisure activities for recreational purposes
3. To establish attitudes and social behavior in accordance with the best standards of the time
4. To aid in the development of mental and emotional poise, power, and control.

The health aspects of physical education and recreation are discussed in Chapter VI.

Healthful School Environment

School hygiene may, in simple language, be defined as practicing what we preach. All environmental conditions should meet the most approved health standards. Buildings should be suitably located, well arranged, and adequate in space, providing proper heating, ventilation, lighting (both natural and artificial), sanitation, cleanliness, safety devices, seating, handwashing and bathing facilities (with hot water, soap, and towels), clinic rooms, and rest rooms for teachers, together with attractive interior decorations and freedom from external disturbances or health menaces. The general school program with its class arrangement, time schedules, and rest or recreation periods should show due consideration to health requirements.

Adequate playgrounds and play equipment are essential. These should include recreational and athletic facilities. The teacher personally is an important health factor. Grooming, manners, and voice are important while ability to maintain stimulating and wholesome pupil-teacher relationships is essential. Chapters VII and XII present many of the environmental problems in school health education.

Mental Hygiene

Special provision should be made for the important factor of mental hygiene in child health and development. It should be so integrated in the complete health program as to lose its identity but at the same time be so positive in its influence as to make it easily recognizable. Chapter VII presents details on this point of view.

Mental abnormalities as reflected in behavior or attitudes need special consideration. The psychologist, the trained home visitor, and the psychiatrist each has a highly important part in the operation of the school. Their placement might vary but it seems logical that they belong with the health specialists.

Teacher Education

Teacher preparation needs must be met by:

1. Adequate facilities and approved standards for training all specialists in health and physical education, such as doctors, dentists, nurses, oral hygienists, physical educators, recreational experts, and special health instructors.
2. Provisions in all teacher-training institutions so that each prospective teacher may acquire the knowledge, skill, attitudes, and habits whereby she may recognize the importance of health in education and whereby she may be able to meet her responsibility in her personal behavior and professional service.
3. Provisions must be made thru conferences, lectures, or other means for in-service preparation by specialists on the staff or by those engaged especially for the service. Summer and extension courses offer opportunities for both specialists and regular teachers.

Cooperation with Nonschool Agencies

In order that the health program may function completely, some scheme must be utilized to bring about cooperation between the school and all the community agencies that are interested in health, both for the purposes of obtaining and giving aid or support. These are of two classes: official and nonofficial. Included in the former are departments of health and their staffs, public welfare departments, and others. In the second group are found such agencies as the American National Red Cross, tuberculosis societies, and public health associations. Relations with state and national agencies are also important.

The Superintendent's Role

To develop the school health program so that it is complete in all its parts, comprehensive in its scope, and well coordinated in its organization is not sufficient. "Plan your work, then work your plan" is the slogan that applies. However excellent the program may be in its completeness, in its adjustments, or in the procedures and technics adopted for its operation, no school health program is worth anything unless it is actually translated into living by those to be served or affected. The school administrator may have a clearly defined concept of health; he may understand the educational processes involved; he may be intelligent and faithful in his planning; but unless he makes the thing "go" he fails in his relation to the school health program. This does not necessarily mean that the administrator himself shall do the work, but if not he shall see that it is done by those capable of doing it.

ESSENTIALS IN THE ORGANIZATION AND ADMINISTRATION OF A SCHOOL HEALTH PROGRAM

1. A clear concept of health and its relation to the educative process.
2. A recognition of the opportunity and responsibility of the school in relation to health.
3. An understanding of the objectives of health education and of the responsibility of the school in reaching these objectives.
4. An acceptance by the school administration of this responsibility.
5. An understanding of what constitutes the comprehensive school health program and the scope and work of each component.
6. A proper placement of health education in the administrative setup of the school or school system.
7. A proper coordination of the several components to secure the best functioning of each unit and the effectiveness of the complete program.
8. The selection of the special staff members with due consideration for the adequate training and necessary qualifications of each.
9. Adequate facilities and necessary allotments in the school time schedule for the work.
10. A definite assignment of work and duties of each staff member.
11. An assumption by each and every member of the school staff of his or her responsibilities and duties.
12. Adequate financial support for salaries, equipment, and supplies.
13. A centralized control definitely established to assure smooth running and maximum achievement in attaining the aims.

The answer to the problem is a variable depending largely on the size of the unit to be served, which ranges all the way from the small one-teacher and sometimes one-pupil school, in many instances remote from any other school, to the school system in our largest city. Obviously, we must expect wide variation in administrative organization There are, however, some fundamentals in any and every case or situation (see page 25).

Of these fundamentals, special emphasis must be placed, first, on assigning to one person the responsibility for administering the complete health program as a unit. That person should be an expert in education. In most school systems the superintendent or the supervising principal must assume responsibility for the coordination. In larger communities a director or coordinator may be assigned. For the very small units the answer lies in establishing areas sufficient in extent and numbers to justify the employment of a competent director. In any event, that which belongs to the school should be kept under the supervision and control of school authority.

Next, the administrator must see that the personnel, both specialists and regular teachers, is qualified. Thru individual and group conferences staff members should learn the nature of their duties.

In fitting the health program into the regimen of the school, due time allowance must be made in the daily and weekly schedules. It should not be necessary for specialists and sectional workers to find their own time or fight for their places in the school activities. The general administrator should attend to this definitely and positively. Needed equipment, supplies, and other facilities must be provided, which again is an administrator's responsibility.

As far as possible there should be included some means of evaluation to determine achievement. Of course in health, as in any other phase of education, complete results can never be known. A regular system of checking can and should be maintained, supplemented by a practicable system of records.

Financial support is essential. To secure this is an obligation resting on the administrator.

And last, the school administrator must give wholeheartedly his official and moral support, making everyone within and without the schools feel that he is back of the health work to the extent that he believes in it and is bound to make it go.

CHAPTER III

Guidance of Individual Pupil Health

ONE OF THE MOST PERPLEXING PROBLEMS facing the school administrator is that of organizing and maintaining an effective health guidance program. This program has to do with discovering the health needs of pupils and planning ways to meet those needs. It was formerly referred to as "medical inspection" and, in some places, as "health service." Plans and procedures must be judged not only by what they do for the individual child but by what they lead him and his parents to do. It is of little value year after year to discover and to announce that William has defective vision—if nothing is done to correct the defect. Little progress is made if the advantages of prevention are discussed in the health program but neither the school nor the community makes it possible for the individual to practice what has been accepted as desirable. In sports the follow-thru is evidence of skill and expertness. In the health program similar effectiveness is possible only when the administrator and his staff continuously and systematically review the outcomes of their efforts.

The Role of Guidance

The problem in health guidance is to recognize the cooperative nature of the activity and to provide thru organization the means for bringing home, school, and community into closer and better relationships for the extension and improvement of the health of each child. Guidance permeates the entire educational process. In actual practice it cannot be isolated without the danger of making it sterile and ineffective. It should not be too limited or labeled as something special in the school program. As an educational activity, it must operate smoothly, naturally, and unobtrusively in accord with the needs of the child, the youth, and the adult.

For purposes of analysis, guidance may be considered as having various aspects:

1. *Biological*—including those activities related to the development of dynamic health

2. *Social*—emphasizing the problems pertinent to the individual as a functioning member of the group
3. *Ethical*—relating to the formations of attitudes and ideals that may be translated into worthy individual and social purposes
4. *Vocational*—stressing activities which contribute to the satisfactory economic life in all aspects of productive individual activity.

Guidance of the individual in any of these aspects must be democratic in its procedures. Even biological guidance cannot be considered as mere indoctrination in certain routine habits or unquestioning adherence to the pronouncements of educators, physicians, or nurses. As an educational procedure within a democratic pattern, it should proceed to develop attitudes and ideals concerning biological needs thru functional teaching. By this process the individual is made conscious of his physical and emotional nature and the need to follow certain procedures and practices which will result in the correction of actual defects, the overcoming of handicapping weaknesses, and the attainment of dynamic health. Guidance is progressive inculcation of attitudes and habits thru self-recognition of needs and the importance of meeting them, instead of blind and rote acceptance of authoritative mandates.

Preventive and corrective measures should be instituted in the preschool and elementary-school years in accordance with accurate knowledge of growth and development. It is immediately obvious that a correction in one area influences the reactions of the whole child and that if we are to have an effective individual good integration is indispensable. The longer poor influences are at play, the more fixed becomes the faulty pattern; and the more fixed the pattern, the more difficult it becomes to change.

Handicaps to robust health, growth, and development lie in several areas—the physical, mental, emotional, and social. The child may be handicapped by heredity, accidents of birth, disease, such common defects as deficient sight or decreased hearing, poor habits of living, lack of sleep, undernutrition, or lack of exercise. He may be handicapped by worry and nervousness incident to the home, school, or community environment. In whichever of these areas the handicap lies, it conditions health. Growth and development are adversely affected, and the resulting behavior of the child is inadequate.

Procedures for Determining Guidance Needs

Discovering the needs of individuals is essential to a sound program of guidance. The ultimate purpose of all individual health programs should be the determination of the health status and the guidance of the individual in an understanding of his responsibility for keeping in dynamic health for personal, social, and vocational efficiency.

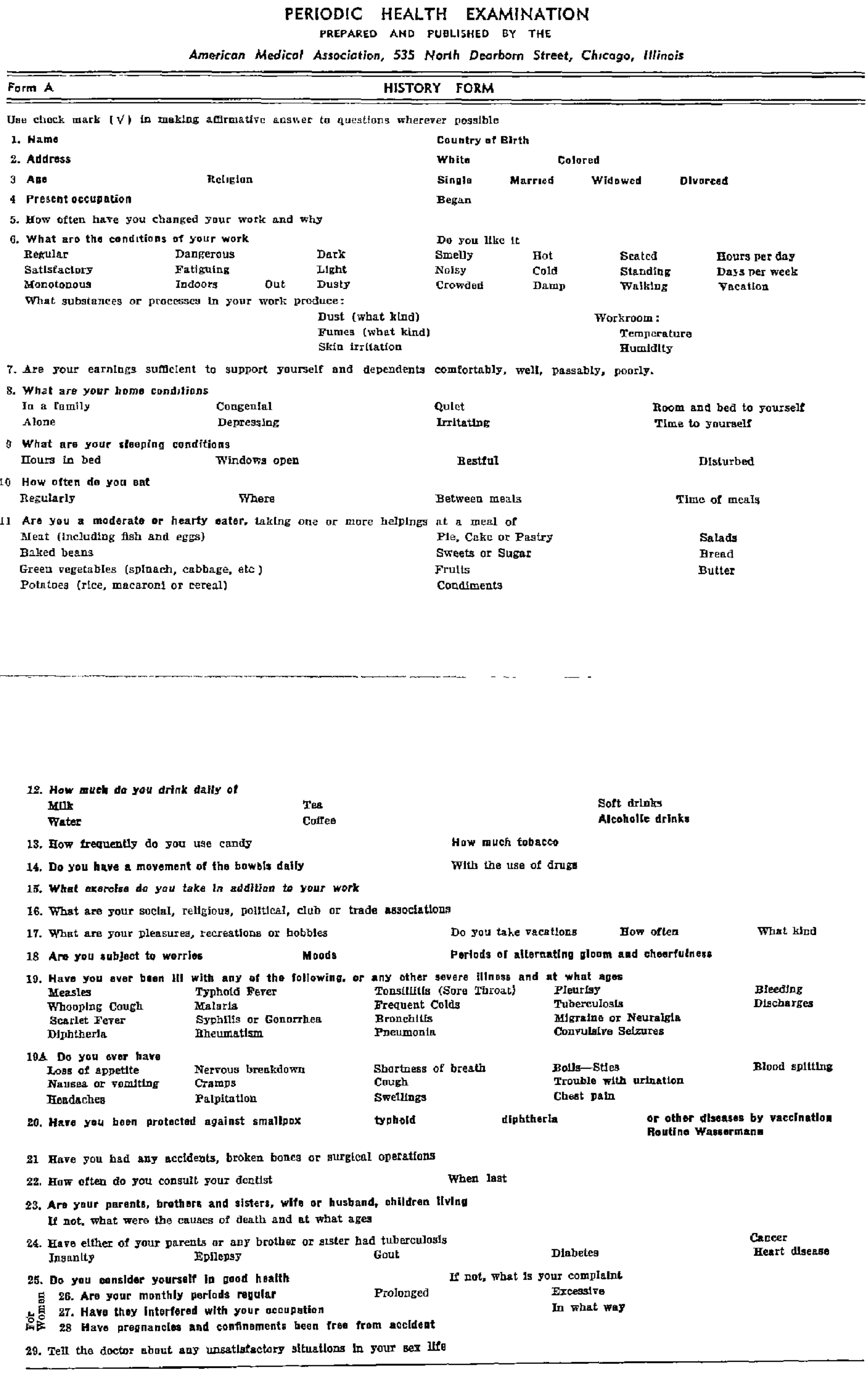
The sources from which the health needs of the child may be discovered are as follows:

1. *The family*
    a. Conferences with the parents to obtain the health history, including a record of medical and dental care prior to entrance into school
    b. Information supplied by the family physician, dentist, and others during the school life of the child
2. *The teacher and school nurse*
    a. Daily health inspections and observations
    b Weighing monthly and measuring height semiannually
    c Observation in school activities with notations of changes in appearance, attitude, and behavior
    d. Periodic health inspections of eyes, ears, nose, throat, teeth, skin, posture, and nutritional state.
3. *Special examinations*
    a. Mental and emotional testing
    b. Dental inspections
    c. Medical examinations.

All the foregoing sources of information are called upon in school systems with outstanding health programs. All can be made available in every school system, even those in rural areas. Thru cooperation with county and state public health authorities, local medical and dental societies, and various public agencies the school administrator can overcome the impediments of distance, public indifference, and finance.

Cooperation with the Family

Under the influence of many agencies, including schools, public health departments, and various private organizations, there has been marked progress in the reduction of deaths and illness in the early years of childhood. Many parents make use of the information and services available in their own communities. Parent-teacher associations, thru their educational activities and summer



PERIODIC HEALTH EXAMINATION
PREPARED AND PUBLISHED BY THE
American Medical Association, 535 North Dearborn Street, Chicago, Illinois

Form A HISTORY FORM

Use check mark (√) in making affirmative answer to questions wherever possible

1. **Name** Country of Birth
2. **Address** White Colored
3. **Age** Religion Single Married Widowed Divorced
4. **Present occupation** Began
5. How often have you changed your work and why
6. **What are the conditions of your work** Do you like it
   - Regular Dangerous Dark Smelly Hot Seated Hours per day
   - Satisfactory Fatiguing Light Noisy Cold Standing Days per week
   - Monotonous Indoors Out Dusty Crowded Damp Walking Vacation
   - What substances or processes in your work produce:
   - Dust (what kind) Workroom:
   - Fumes (what kind) Temperature
   - Skin irritation Humidity
7. Are your earnings sufficient to support yourself and dependents comfortably, well, passably, poorly.
8. **What are your home conditions**
   - In a family Congenial Quiet Room and bed to yourself
   - Alone Depressing Irritating Time to yourself
9. **What are your sleeping conditions**
   - Hours in bed Windows open Restful Disturbed
10. **How often do you eat**
    - Regularly Where Between meals Time of meals
11. **Are you a moderate or hearty eater, taking** one or more helpings at a meal of
    - Meat (including fish and eggs) Pie, Cake or Pastry Salads
    - Baked beans Sweets or Sugar Bread
    - Green vegetables (spinach, cabbage, etc.) Fruits Butter
    - Potatoes (rice, macaroni or cereal) Condiments

12. ***How much do you drink daily of***
    - Milk Tea Soft drinks
    - Water Coffee Alcoholic drinks
13. How frequently do you use candy How much tobacco
14. **Do you have a movement of the bowels daily** With the use of drugs
15. ***What exercise do you take in addition to your work***
16. What are your social, religious, political, club or trade associations
17. What are your pleasures, recreations or hobbies Do you take vacations How often What kind
18. **Are you subject to worries Moods Periods of alternating gloom and cheerfulness**
19. **Have you ever been ill with any of the following, or any other severe illness and at what ages**
    - Measles Typhoid Fever Tonsillitis (Sore Throat) Pleurisy Bleeding
    - Whooping Cough Malaria Frequent Colds Tuberculosis Discharges
    - Scarlet Fever Syphilis or Gonorrhea Bronchitis Migraine or Neuralgia
    - Diphtheria Rheumatism Pneumonia Convulsive Seizures

19A. Do you ever have
- Loss of appetite Nervous breakdown Shortness of breath Boils—Sties Blood spitting
- Nausea or vomiting Cramps Cough Trouble with urination
- Headaches Palpitation Swellings Chest pain

20. **Have you been protected against smallpox typhoid diphtheria or other diseases by vaccination**
    Routine Wassermann
21. Have you had any accidents, broken bones or surgical operations
22. How often do you consult your dentist When last
23. **Are your parents, brothers and sisters, wife or husband, children living**
    If not, what were the causes of death and at what ages
24. Have either of your parents or any brother or sister had tuberculosis Cancer
    Insanity Epilepsy Gout Diabetes Heart disease
25. **Do you consider yourself in good health** If not, what is your complaint

For Women
26. **Are your monthly periods regular** Prolonged Excessive
27. **Have they interfered with your occupation** In what way
28. **Have pregnancies and confinements been free from accident**

29. Tell the doctor about any unsatisfactory situations in your sex life

FIGURE IV.—A. M. A. HEALTH EXAMINATION FORM

roundup program, have done much to make families aware of the health needs of children. Few pupils enter school today without having had some medical care, vaccinations, immunizations, dental examinations, or other skilled attention. Conferences with the parents should deal not only with the child's past medical history but with the findings of examinations thruout the entire period of school attendance.

Health history—An indispensable part of the school's health guidance program is the health history of each pupil. It has been said that a good history is a better guide for the health adviser than a medical examination. This statement is somewhat exaggerated, but in dealing with an apparently healthy or average child, certainly if it were a choice between a good history and an unreliable examination, the history should be chosen. It is true that a physical examination without a history is inadequate and has no place in the health education program. It is better to limit the examination and keep the history up to date. Principals and teachers, with the assistance of the school nurse, should go to all necessary lengths to get a good history.

Some aspects of the health history are best obtained by an interview with the parent, preferably by the school medical adviser. When the physician has the privilege of an interview with the parent, he will not only learn more about the child but he will have an excellent opportunity to understand the parent. This may give him considerable insight into the behavior of the child.

The school health examination frequently has carried little or no space for history records. At the most, the history has consisted of a checklist of childhood diseases, an undated checklist of immunizations, and occasionally a list of corrected defects of tonsils, teeth, and eyes. Figure IV illustrates the individual history items that might be included in school record forms.

Without a health history the doctor will have no evidence of certain conditions or symptoms that are preclinical signs of disease. He may be left completely ignorant of school progress, behavior, and personality problems. Such conditions as headaches, recurrent attacks of bronchitis, shortness of breath, asthma, hay fever, abdominal pain, vomiting, diarrhea, frequent urination, recognized heart and kidney disease, and diabetes might be left out of consideration.

The school staff will find a dependable history invaluable in the guidance program. All the data found on this form, from the identifying data to the parents' comments, should be used. It is convenient to know if the child has a family doctor. It is a relief to know that a child exposed to measles has had measles and is probably immune. A child suffering from some abdominal pain, with vomiting, may have previously been operated upon for appendicitis. If the tonsils are out and the teeth are regularly cared for—these facts are important and useful to know. A child who fails to gain weight over a period of three successive months has always been a problem and should be under the close observation of his doctor. In addition, the teacher and the nurse can be more discriminating in the observations they add to the record. As a result, the child's guidance program will be better defined.

The essential items in a health history are as follows:

1. *Identifying data:* name; address; parents' names, nationality, religion; father's occupation; mother's occupation; medical and dental advisers' names and addresses.
2. *Family history:* appraisal of environment and hereditary trends, age and state of health, presence of disease in parents, siblings, or grandparents, and cause of death of deceased members of the family.
3. *Personal history:*
    a. Diseases, accidents, and operations
        Abnormalities of birth
        Diseases and dates
        Accidents and dates
        Operations and dates.
    b. Immunizations, skin tests, and vaccinations (with dates)
    c. Complaints present
    d. History of exposure to disease, for example, tuberculosis
    e Dental examinations (last date)
    f. Health habits of rest, sleep, nutrition, play
    g. Eye examinations (last date)
    h. Parents' comments: regarding general health, endurance, and intellectual, emotional, and social behavior and attitudes
    i. Menstrual history—girls aged eleven years and up
    j. Source of information or signature of parent
    k. Date of the report.

The placement of many of these items upon a typical school record form is shown in Figures V and VI. How well these records

HEALTH HISTORY

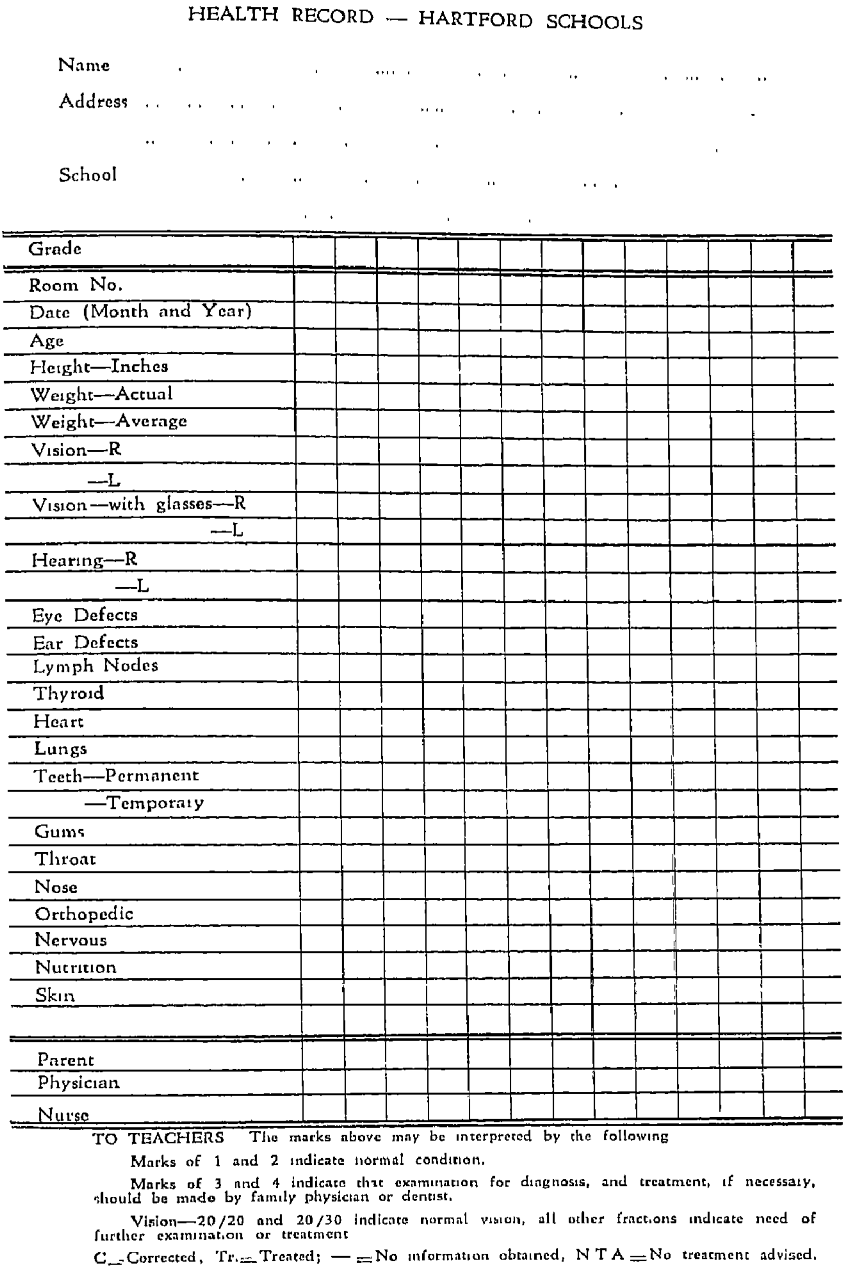
Disease	Date of Sickness	Disease	Date of Sickness
Diphtheria		Smallpox	
Measles		Infantile Paralysis	
Whooping Cough		Discharging Ears	
Scarlet Fever		Pneumonia	
Rheumatism		Convulsions	
Frequent Colds		Mumps	
Chorea			

Special Treatments or Tests	Date	Results or Other Comments
Smallpox Vaccination		
Diphtheria Immunization		
Schick Test		
Mantoux Test		
X-ray		

Notes by nurse or teacher on school adjustments, causes of absence or special recommendations.

Date	

FIGURE V.—HARTFORD, CONN. RECORD *(FRONT)*



HEALTH RECORD — HARTFORD SCHOOLS

Name

Address

School

Grade													
Room No.													
Date (Month and Year)													
Age													
Height—Inches													
Weight—Actual													
Weight—Average													
Vision—R													
—L													
Vision—with glasses—R													
—L													
Hearing—R													
—L													
Eye Defects													
Ear Defects													
Lymph Nodes													
Thyroid													
Heart													
Lungs													
Teeth—Permanent													
—Temporary													
Gums													
Throat													
Nose													
Orthopedic													
Nervous													
Nutrition													
Skin													
Parent													
Physician													
Nurse													

TO TEACHERS The marks above may be interpreted by the following

Marks of 1 and 2 indicate normal condition.

Marks of 3 and 4 indicate that examination for diagnosis, and treatment, if necessary, should be made by family physician or dentist.

Vision—20/20 and 20/30 indicate normal vision, all other fractions indicate need of further examination or treatment

C=Corrected, Tr.=Treated; —=No information obtained, N T A=No treatment advised.

FIGURE VI.—HARTFORD, CONN. RECORD *(REVERSE)*

are kept in complete and up-to-date form depends largely upon the organization developed by school administrators. Where indifference prevails or proper blanks are lacking the results are likely to be unsatisfactory.

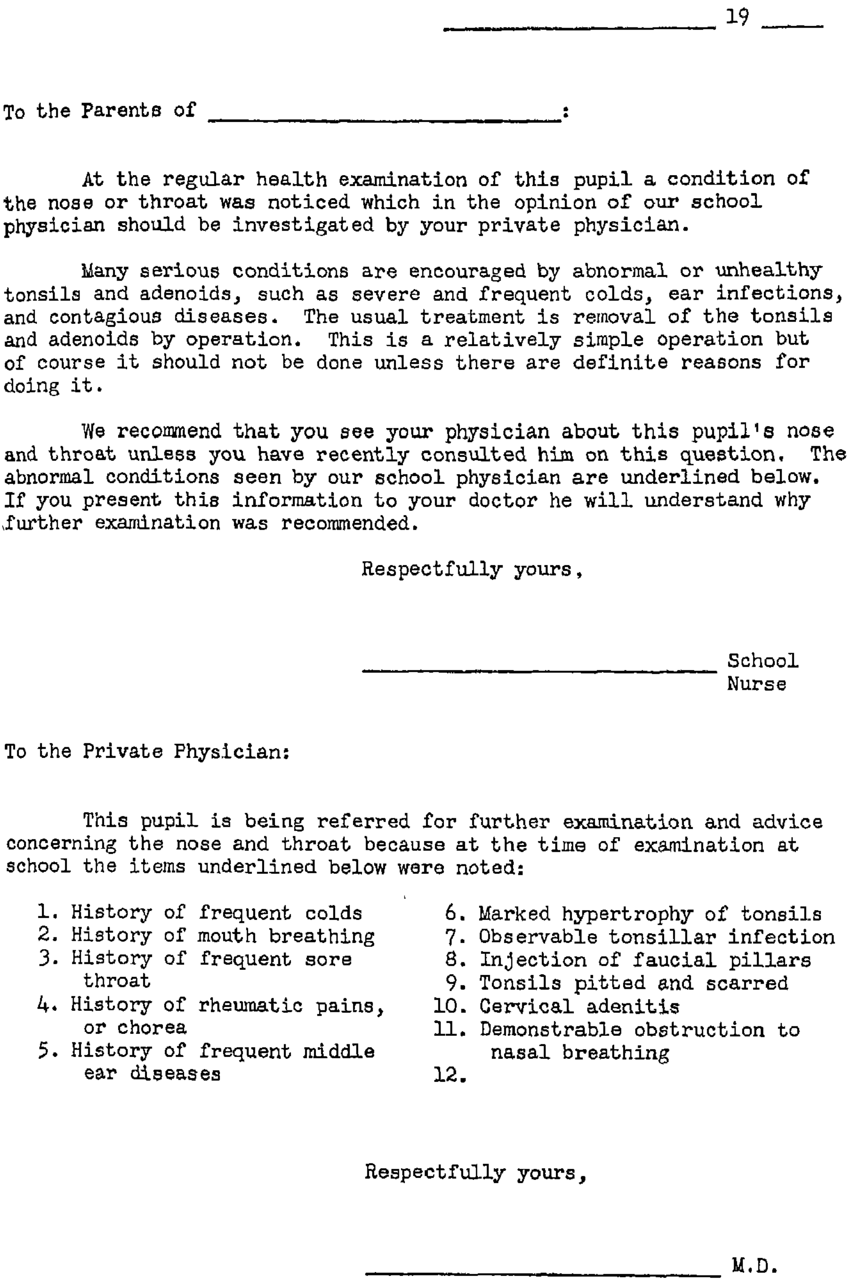
Conferences with parents—The physical examination is usually more significant when the parent accompanies the child. With the nurse recording, the work is expedited and the activities of the physician and the nurse are harmonized. Here is a teaching situation where the doctor has an opportunity to explain the findings.

Conferences should be "give and take" affairs, for the carrying out of recommendations will depend upon the conviction of the parent, child, teacher, and nurse. The recommendations must be understood, acceptable, practiced, and reinforced if they are to produce action. Significant weaknesses and strengths revealed by the history and the physical examination are brought into relief. Why are good health habits so important? Why must one have adequate sleep, a balanced diet, and good muscular development? Why must marked correctable defects be cared for immediately? With the adolescent, acne, irregularities of growth, sexual development, and coordination need to be discussed with clarity and sympathy.

The recommendations of the family doctor can be reinforced. The medical adviser presents his reasons for suggested changes in the child's school program. The child may be referred to the family physician or dentist for further examination or treatment. Where the family needs financial assistance to obtain clinical services, proper direction to the community resources should be given. Where possible the assistance of the nurse can be enlisted to carry on.

The conference is the time when the medical adviser can gain the confidence of child, family, and teacher. The child, and particularly the adolescent, who has been impressed with the friendliness, sincerity, and capability of the medical adviser, will make use of his opportunities to return with his problems.

The findings of physical examinations and conferences should be made a matter of record for school and family. It is good practice to give the parent a written report. In the absence of the parent, a suitable statement may be sent to the home. On occasion, the medical adviser will confer with the attending or family physician. It is advisable to give the family physician or dentist a report of the find-



____________________ 19 ____

To the Parents of ______________________________:

At the regular health examination of this pupil a condition of the nose or throat was noticed which in the opinion of our school physician should be investigated by your private physician.

Many serious conditions are encouraged by abnormal or unhealthy tonsils and adenoids, such as severe and frequent colds, ear infections, and contagious diseases. The usual treatment is removal of the tonsils and adenoids by operation. This is a relatively simple operation but of course it should not be done unless there are definite reasons for doing it.

We recommend that you see your physician about this pupil's nose and throat unless you have recently consulted him on this question. The abnormal conditions seen by our school physician are underlined below. If you present this information to your doctor he will understand why further examination was recommended.

Respectfully yours,

______________________________ School Nurse

To the Private Physician:

This pupil is being referred for further examination and advice concerning the nose and throat because at the time of examination at school the items underlined below were noted:

1. History of frequent colds
2. History of mouth breathing
3. History of frequent sore throat
4. History of rheumatic pains, or chorea
5. History of frequent middle ear diseases
6. Marked hypertrophy of tonsils
7. Observable tonsillar infection
8. Injection of faucial pillars
9. Tonsils pitted and scarred
10. Cervical adenitis
11. Demonstrable obstruction to nasal breathing
12.

Respectfully yours,

______________________________ M.D.

FIGURE VII.—HARTFORD (CONN.) FORM LETTER TO PARENTS

ings but not to give detailed recommendations of what needs to be done. Figure VII illustrates one type of form letter now in use.

The intraschool health guidance program begins in earnest at the conclusion of the conference. The health guidance programs of the school and the home must reinforce and supplement each other. When a thoughtful, simple guidance program is mapped out, it should be followed in detail. When advice in regard to improvements in health performance is ignored either by the family or the school, the child suffers. Ignored or inaccurate medical advice is prone to discount all professional services and health education in general. From experience it would seem wise to limit, explain, and follow every suggestion that is given; otherwise, the logical course of events may be as follows:

> Logic is often forgotten in the health education program. Recently, in a paper as yet unpublished, Turner cited an example of what happened to a health educator (it is assumed that all public health workers are health educators whether they know it or not) who forgot about logic. The pupils did not forget about it. Here is what happened A child, being asked what he must do to preserve the health of his teeth, answered in effect. "The books say they must be kept clean and we must eat lots of fruit and vegetables, and drink milk, but you don't have to do it because there's a dentist in school all the time to fix them up."[1]

Observations by Teachers and Nurses

When examinations by physicians are not possible, careful observations by nurses and teachers are particularly important. A bulletin, *Health Inspection of School Children*,[2] outlines procedures that can be carried out by the nurse or the teacher. These instructions were prepared especially for school situations where a physician's time was either not available or limited.

This Joint Committee monograph describes the minimal equipment and a series of technics that may be used by nurse or teacher to inspect, measure, weigh, and test for height and weight, behavior habits, posture and gait, nutrition, skin, eyes (vision), nose, mouth and gums, teeth, tonsils, throat, adenoids, glands of neck, thyroid, ears, chest, spine, extremities, feet, and general condition.

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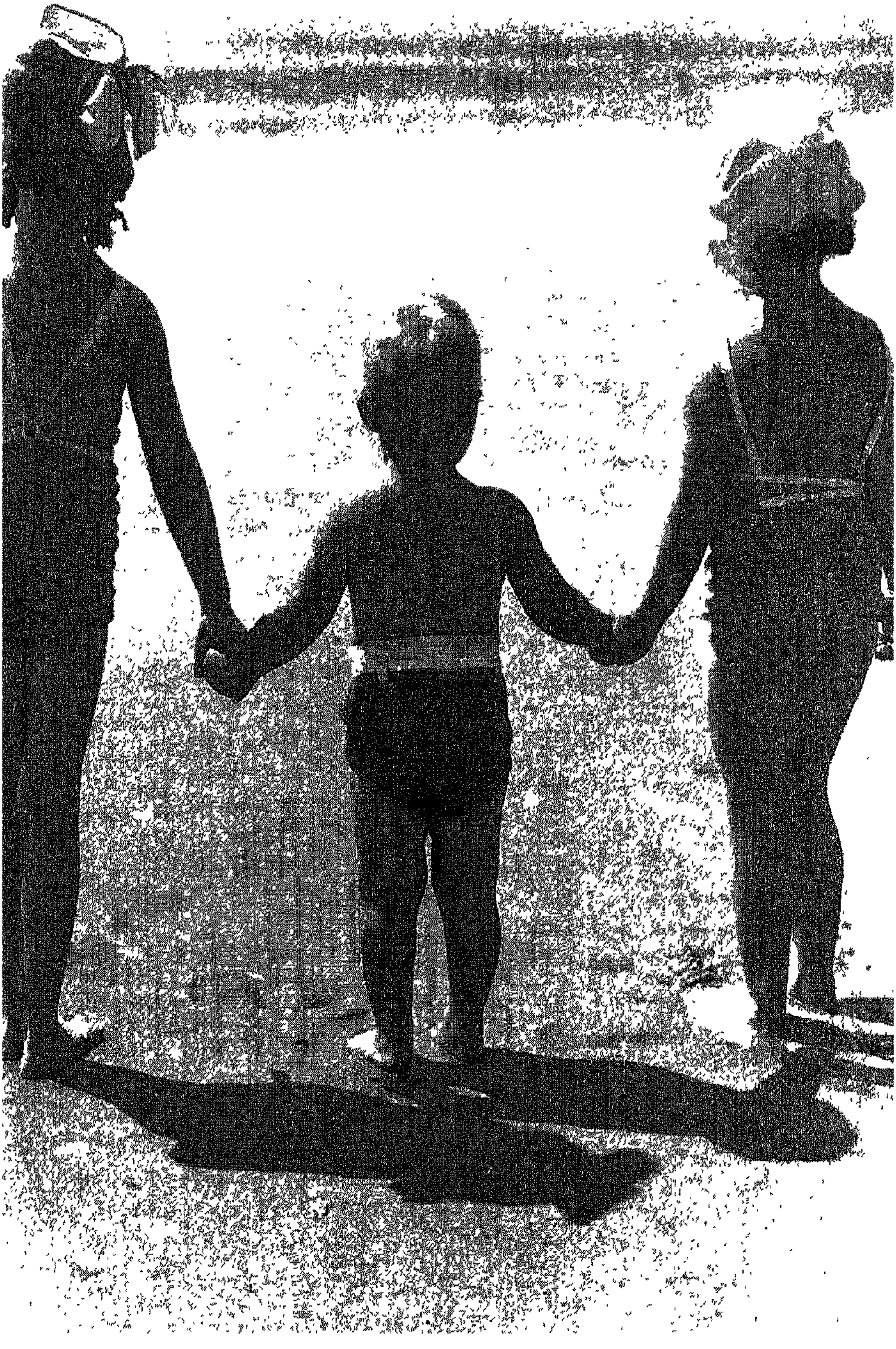
[1] Bauer, W W "A Philosophy of Public Health Education." *Proceedings*. Seventh Institute on Public Health Education of the American Public Health Association, Detroit, Michigan, October 6, 1940 Also in second revised edition of *Health Education of the Public*, by W. W. Bauer and Thomas G Hull (Philadelphia· W. B. Saunders Co., 1942).

[2] National Education Association and American Medical Association, Joint Committee on Health Problems in Education. *Health Inspection of School Children* Washington, D C., the National Education Association, 1933, 23 p



HEALTH HABITS EARLY IN LIFE—*In the home are initiated many of the health habits and attitudes upon which the school will build its program. Sunshine, play, sleep, good food, and interesting activities during the preschool period help to build the resources so necessary later. Every effort should be made to help parents send happy and healthy children to school.*

Photograph by
Fred Hess, Atlantic City

Daily health inspection by the teacher—An important source of information is the result of keen daily observation by the teacher. It is usual for the room teacher to make a daily inspection of each child. The first objective of this inspection is to detect signs of beginning disease such as colds, red eyes, high color, sniffles, infected throat, rashes; abnormal attitudes disclosed by facial expressions of weariness; complaints of headache and stomach-ache; and irritability. The teacher's daily inspection, noting changes in appearance and behavior, is invaluable in recognizing early signs of communicable disease and in observing the personal hygiene of the child. Specific details as to the common signs of communicable disease and the steps which should be taken are given in Chapter X.

Screenings and special tests—Certain procedures such as weighing and measuring are unusually good teaching devices and as such could well be left to the teacher. Weighing and measuring are useful devices when understood and correctly used. Gains in height and weight vary with the individual. Each child is a pattern unto himself and his rate of growth will vary seasonally, increasing in summer and fall, according to his heredity and eating habits. However, in addition to the above factors, influencing both gains in weight and in height, sickness and other unsatisfactory conditions of living may cause a temporary and unexpected retardation. Formerly, measures of height and weight were considered adequate indexes of nutritional state. Now it is recognized that reasonably exact measures of nutritional state are not available. This decision has been reached as a result of intensive research.

The medical adviser must decide when the nutritional state is satisfactory. The medical adviser comes to a decision when he has examined the child and knows the history of the child and the quality and quantity of musculature, subcutaneous tissue in addition to the height and weight.

The teacher or nurse should weigh the class monthly and measure height semiannually. The conditions under which the children are weighed and measured should be standardized, that is, measurements should be taken at the same time of day, the same clothes should be worn, and bowels and bladder should be empty. The technic should be standardized; scales and wall measures must be accurate. Data should be recorded systematically. Children showing no gain in three successive months should be automatically referred to the medical adviser for an explanation. In matters of nutrition, the teacher and the nurse will do well to confine their health instruction to a presentation of the importance of the basic diet.

It is exceedingly important for a child to understand that variations in growth exist and that his pattern is unique. Adolescents especially are prone to compare themselves with their classmates, and when they do not compare favorably they may become apprehensive. No personal health attribute should be made an objective for competition.

Studies over a period of years have demonstrated the teacher's ability to perform health inspections.[3] In general, because of the many demands on the classroom teacher, she should be expected to carry out only those tests and procedures which are direct teaching aids. The teacher may be prepared for these duties by the doctor or the nurse thru continuous in-service training. Since these activities are closely related to the daily work of the teacher, the principal should help teachers to have both the time and necessary facilities for these observations.

Continuous observation by teacher—The alert teacher is able to detect many conditions which may not be revealed by the health examination. The child who is constantly inattentive attracts attention. Does he hear the discussion? Does he see the board? Can he read the printed page? Is there some physical cause that makes him so apathetic that his interest wanders? Is he bored by class procedures or is he unable to keep up? What are the health difficulties behind these conditions?

Observation of the children at play may be equally revealing of physical health and of social and emotional attitudes. There are children who always prefer quiet and retreat from active play—why? There is the child who occasionally declines to play and also the child who can never lose himself in the group play, who continues to be so individualistic that he is always left out. The chronic complainer, the shy, the awkward, the belligerent, the overactive child should be observed and accurate diagnosis and well-planned, systematic guidance secured. All such obvious handicaps as have been

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[3] Wheatley, George M. "Case-Finding Procedures Developed by the Astoria School Health Study." *The Child* 4 283-91, May-June 1940.

SYMPTOMS OBSERVED BY TEACHER Class→											
EYES	Styes or Crusted lids										
	Inflamed eyes										
	Crossed eyes										
	Frequent headaches										
	Squinting at book or blackboard										
EARS	Discharge from ears										
	Earaches										
	Failure to hear questions										
NOSE AND THROAT	Persistent mouth breathing										
	Frequent sore throat										
	Recurrent colds										
GENERAL CONDITION AND APPEARANCE	Very thin										
	Very fat										
	Does not appear well										
	Tires easily										
	Poor muscle coordination										
	Bad posture										
BEHAVIOR SYMPTOMS	Emotional disturbances										
	Speech defect										
	Twitching movements										
	Nervousness										
	Undue restlessness										
	Shyness										
	Nail biting										
	Excessive use of lavatory										
HEALTH HABITS	Poor sleep habits										
	Poor food habits										
ABSENCES FOR ILLNESS	Write Causes Below Enter No. of days absent in "class" column										
	Colds										
	Stomach upset										
	Others (specify)										

FIGURE VIII.—TEACHER OBSERVATION RECORD

indicated should be noted by the teacher. As the teacher becomes more experienced, she will become increasingly discriminating in selecting the cases with which she will deal herself and those she will refer to the specialist. To fulfil these functions, it is obvious that observation of children must be thought of as a continuous process—something that goes on thruout the school day.

A pupil health card provides a simple means of recording these informal observations by the teacher (see Figure VIII). These brief notations may be easily reviewed by nurse or doctor and followed up according to their importance. The important skill to be developed by the teacher is that of knowing when to call upon the services of the specialist. At this point the school administrator can be helpful by arranging for conferences, clinics, and booklets of information whereby the teacher may become alert to typical situations and to the possibilities of expert aid.

Special Examinations

Previous sections of this chapter have dealt with the importance of conferences with parents and with the observations of teachers and nurses as sources of information in guiding the health of the child. Important as these systematic explorations are, alert administrators have found it necessary to provide for three general types of examinations by specialists.

Mental testing—Every teacher is aware of the fact that there are great differences among pupils with respect to their mental abilities. These differences have been demonstrated for many years, particularly with respect to intelligence or the ability to do schoolwork. While classroom teachers are often prepared to give group tests of intelligence as a screening process, the individual test is best given by experienced psychologists. The necessity for skilled attention in cases of suspected abnormality is discussed in Chapter VII.

Emotional or personality difficulties, often called behavior problems, usually require skilled attention. Teachers often recognize these cases thru such overt signs as bullying, masturbation, timidity, excessive fears, dishonesty, daydreaming, and unhappiness. That teachers do not always recognize the significance of atypical behavior has been shown by various studies.[4] With the help of such publications as *Mental Hygiene in the Classroom*,[5] teachers may do much to discover these maladjusted children and to alleviate many of the conditions associated with each case. In giving the various tests of personality (see Appendix list) and interpreting the results, classroom teachers need the help of persons trained in the fields of psychology and psychiatry. The preventive aspects of mental hygiene are discussed in Chapter VII.

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[4] Wickman, E. K. *Children's Behavior and Teachers' Attitudes.* New York, Commonwealth Fund, 1928. 247 p.

Dental examinations—It has been said that nine out of every ten children selected at random in any schoolroom will be found to have one or more decayed teeth. Recent reports of the young men rejected by draft boards show that defective teeth is one of the most prevalent physical disabilities. The importance of sound teeth and a healthy mouth can be stressed by the classroom teacher and by school nurses.

Nyswander reported from the Astoria, New York, survey:

> Experience indicated that the dental health of school children in Astoria would not be improved by better case finding techniques in the school. Two things were needed, namely, education in the values of dental care and dental service In two experiments emphasis was placed on these aspects. In one the dental hygienist assumed the responsibility for instructing children and parents; in the second the classroom teachers took over the task. In both experiments the private dentists gave most of the treatment services.
>
> Both procedures brought comparable results but it is evident that the dental hygienist who conducts such a program for an entire school would be sorely taxed for time to give prophylactic treatments or assistance to the dentist in the clinic. Furthermore it is now out of keeping with sound educational theory in health education to overemphasize one program (such as dental) without regard to all other educational efforts providing for the child's welfare. The child cannot be helped to form sound attitudes toward assuming future responsibilities for his health through campaign methods of specialists. His teaching must be unified through one source of instruction—the teacher.[6]

A general program of dental examinations is outlined in the bulletin *Mouth Health of School Children*.[7] Possibilities as to administrative policies and cooperation between community agencies will be

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[5] National Education Association and American Medical Association, Joint Committee on Health Problems in Education. *Mental Hygiene in the Classroom*. Washington, D. C : the National Education Association, 1939. 70 p.

[6] From an unpublished study by Dorothy B. Nyswander. Report to be issued by the Commonwealth Fund early in 1942

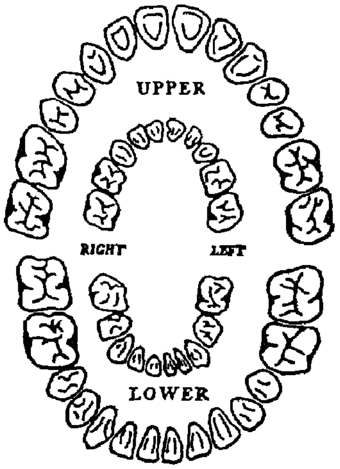
[7] National Education Association and American Medical Association, Joint Committee on Health Problems in Education *Mouth Health of School Children*. Washington, D C · the National Education Association, 1938 66 p.

Name_______________(Last)_______________(First)_______________Date of birth_______________ Color W C Sex M F

Address_______________

Father's name_______________Mother's name_______________

ORAL EXAMINATION RECORD



School and Grade						
Date of examination		19	19	19	19	19
Oculation and mastication	Good					
	Fair					
	Poor					
Stains	None					
	Some					
	Much					
Calculus	None					
	Some					
	Much					
Color of gums	Pink					
	Light					
	Dark					
Number of cavities	Temp.					
	Perm					
Number of roots and abscesses	Temp					
	Perm.					
Coated tongue						
Use of brush	Daily					
	At times					
	Never					
Number of fillings	Temp.					
	Perm.					

CODE
C—Caries F—Fistula
M—Missing tooth *R—Roots remaining*

Draw line from defect and indicate character and number of examination thus: C¹ (cavity at first examination).

(Name of organization)

DENTAL EXAMINATION

FIGURE IX.—DENTAL EXAMINATION FORM

found in "Suggested School Health Policies" [8] and *Social Services and the Schools.*[9] Chapter XV also indicates certain cooperative community procedures. The Commonwealth Fund suggests the oral examination card shown in Figure IX.

Medical examinations—In addition to appraising the health status of pupils, the health examination is now recognized as an educational experience contributing to pupils' understanding of health. It influences their attitudes toward health and toward physicians and nurses; it affords opportunities for giving information related to their individual problems. Consideration of educative values requires that attention be given to the attractiveness of rooms used for examinations, the personality of personnel, and the procedures used. The examination should be a pleasant experience, conducted in privacy in as attractive a room as is available and with due consideration by examining personnel to pupils' feelings. The physician and nurse should give individual attention to pupils during examinations, talk with them, give opportunities for questions, and answer these as fully as possible. Only thru attention to these matters can the examination be made to contribute most to the health education of pupils.

The main purpose of the school health examination is not to make a detailed diagnosis but rather to review the health status of the child with the idea of bringing into relief handicaps of body and mind which need further observation, treatment, and guidance. As a result of this examination, the school medical adviser is able to determine, sometimes in a specific way and sometimes in a more general way, what further medical care is needed, what educational adaptations are required, or what changes in the child's personal life may be necessary.

It goes without saying that a sound knowledge of the characteristics of the growing and developing child is basic to this undertaking, as it is to the whole problem of health guidance. A number of recent growth studies have increased insight into this important field.[10]

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[8] National Committee on School Health Policies. "Suggested School Health Policies." *Journal of Health and Physical Education* 11: 283-86, 333-35, 358-61, 389-91; May-June 1940.

[9] National Education Association and American Association of School Administrators, Educational Policies Commission *Social Services and the Schools.* Washington, D. C.: the Commission, 1939. 147 p

[10] Frank, Lawrence K. "Problems of Child Development." *Child Development* 6: 7-18; March 1935 ¶Keliher, Alice V *Life and Growth.* Progressive Education Association, Commission on Human Relations Series New York D. Appleton-Century Co , 1938. 245 p ¶ Olson, W. C *Concepts in Human Development of Importance for the Education of Teachers.* Lecture given at the Teacher Education Conference at the School of Education, University of Michigan, July 18, 1940.

It is well recognized that while growth and development proceed in an orderly sequence from infancy to adulthood, all organs and processes do not mature in parallel at a regular rate. For example, an eight-year-old child may have grown to be as large as a twelve-year-old child and will continue to behave intellectually and emotionally as a child of his chronological age. The important fact is to recognize certain broad indexes and to realize that each child is a pattern unto himself. These irregularities of growth and development become most apparent at puberty, and here they become especially important because the adolescent is likely to be concerned over his growth phenomena.

Where possible every child should have a thoro preschool health examination by the family physician. Indicated immunizations and correction of defects should be cared for before the child enters the school. A full report of the findings and recommendations of the examining doctor should go to the home as well as to the school and be incorporated in the health guidance plan that will follow.

In the best medical practice the individual's health guidance plan begins at birth and is carried out consistently until death. It is understood in any health examination that the personality make-up and the behavior patterns of the child should be given equal consideration with the physical aspects.

Many children, however, do not have the advantage of either a family doctor or a preschool examination. It has been necessary, therefore, for the schools to incorporate into their health guidance program the so-called periodic health examination. However, the best school examination cannot take the place of the series of examinations done by the family doctor, or his alternate, the medical clinic. One of the advantages of a private medical examination is that the office or the clinic is equipped to carry out the necessary laboratory tests and treatments. However, even the best general physicians need understanding of the school's program if they are to cooperate fully. By working with the local medical society the school administrator can develop the kind of intelligent cooperation required.

In the American Medical Association monograph on periodic health examinations, the schedule for the minimum frequency of the periodic examination is as follows:

Prenatal: monthly to bi-weekly
First 6 months: bi-weekly; second 6 months. monthly.

One to 2 years: quarterly.
Two to 5 years: semi-annually.
Five to 15: every 2 to 3 years.
Fifteen to 35: every 2 years.
Thirty-five to 60: annually.
Above 60: semi-annually.[11]

Indications for more frequent repetition of the health examination arise when a child shows changes in appearance and behavior; then the teacher or nurse should immediately send the child to the school doctor or urge the parents to take him to the family doctor.

The average child could well be examined twice during the high-school years—at entrance and before graduation. The last examination may be combined with that required for a "work certificate."

A minimum list of the specific tests to be made is as follows:

1. eyes and lids
2. ears, canals, and drums
3. nose
4. teeth and gums
5. throat and mouth
6. lymph nodes
7. thyroid
8. heart before and after exercise
9. lungs
10. nutrition
11. skin
12. orthopedic defects
13. posture
14. hernia
15. feet
16. nervous system
17. speech.[12]

Regardless of the frequency of examinations, it must be emphasized that all examination procedures should be supplemented by the day-by-day observation of pupils by teachers and referral to the school medical adviser or school nurse of those who show deviations from normal. This concept is based on a recognition of health guidance as a cooperative venture of teachers, nurses, and physicians. In past years, some schools unfortunately organized their health efforts in a way which required physicians and nurses to work independently of teachers, with the consequence that these special health workers were considered as auxiliary to the school staff rather than an integral part of it. We now know that physicians and nurses working without coordination of their efforts with those of teachers cannot conduct an ideal, functioning health guidance program. In order to achieve coordination of the efforts of teachers, nurses, and physicians, the school principal should plan for joint meetings of these members of his staff. These meetings may be used for planning, for developing new procedures, for discussing the particular contribution of each and how it fits into the whole program, and for devising methods of evaluating the results of health guidance.

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[11] American Medical Association. *Periodic Health Examination* Chicago: the Association, 1940, p 7.
[12] Smiley, D F "An Approach to the Problem of School Medical and Dental Service." *Journal of the American Medical Association* 108, 435-39, February 6, 1937.

The present trend is to de-emphasize the *annual* periodic school health examination. In many cases, the time consumed by the annual repetition of the examination used all possible time available of medical, dental, nursing, and teaching staff. Annually, defects of vision, hearing, teeth, tonsils, nutrition, and personality were rediscovered, recorded, and filed away. Lack of personnel has led to hasty, perfunctory, and inexpert examinations so that no effort could be made to sort out even those cases needing immediate medical care. Emphasis was placed on examinations as such, and it naturally followed that no in-school guidance program worthy of the name could be anticipated. Reviews and studies of existing conditions have pointed out the necessity for a complete revision of this service.[13]

The school medical adviser needs more free time not only to review the results of the medical examination but to plan the health guidance program.[14] He needs free time to confer with the school personnel, teachers and maintenance staff, pupils, family, family physician, public health officers, and representatives of medical societies and of other health and welfare agencies. He should plan and participate in the in-service health education training program of the school. The school medical adviser must have time to keep abreast of his field. He should be familiar with such studies as Olson's investigations of growth or maturation of the body and its effect upon learning.[15] Attempts to evaluate development and physical status *over a period of years*[16] have greater significance for education than has been generally recognized. It is toward this area that the school administrator should direct some of the skill of his medical staff.

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[13] Consult: American Child Health Association. *Physical Defects; the Pathway to Correction.* New York: the Association, 1934. 171 p ¶Spock, Benjamin. "The Changing Task of the School Physician." *Progressive Education* 16: 576-81: December 1939.

[14] Wheatley, George M , *op cit.*

[15] Olson, W C , *op cit.*

[16] For example Wetzel, Norman C "Physical Fitness in Terms of Physique, Development, and Basal Metabolism." *Journal of the American Medical Association* 116: 1187-95; March 22, 1941.

Solving Health Problems thru School Procedures

The purely medical and dental aspects of the guidance programs are directly concerned with further specialized care and supervision. In general, following the school health examination, further diagnoses, corrections, and treatment are to be referred to the family or to the community health agencies. The coordination of health agencies is discussed in Chapter XV of this yearbook.

The school has the responsibility for assuring that procedures recommended by the school medical adviser are carried out. This medical follow-up frequently entails educating the parents as well as the child in the importance of carrying out the doctor's advice. With the coordinated effort of administrator, medical adviser, nurse, and teacher, and even with the best cooperation the family can provide, the school may have to assume the responsibility for all services short of medical treatment.

The school authority, with the assistance of the county, district, or parish medical society, may find it necessary to recommend the private doctor or health agency, find means of financing the visit, make the appointment, and transport the child to and from the clinic. It is obviously unsound to use health advice alone, when definite disease has been found even in the so-called "healthy."

When the teacher is approached with the problem of health guidance, she will find the greatest advantage in having a complete history of the child. It is desirable to know everything possible about the child—his heredity, economic status, living conditions, home life (important physical and mental characteristics of parents, brothers, and sisters), history of disease, health practices, and intellectual, emotional, and social make-up.

The health record must be easily available to the teacher. Thru an increasing knowledge of the child, gained by the observation of his behavior and his attitudes, the teacher adds pertinent facts to the health history. Periodic conferences with the child concerned, with respect to extraschool activities, may be especially helpful in appraising the child's total program, particularly on the high-school level. All children need supervision to reinforce good patterns of living and to prevent formation of unsatisfactory practices.

Careful inventory of the school child's health needs permits of classification. Some children need (a) marked change in home or community environment; (b) special classes; (c) further care by the medical and allied professions; (d) improvement in health habits; (e) mental hygiene on the personality and behavior levels in mental, social, emotional, and moral guidance; or (f) institutionalization.

a. *Marked change in home and community environment*—The school authority may be called upon to assist in the readjustment plan. The problem may be referred to the proper community or state agency.

b. *Special classes*—Where the child needs special instruction with regard to vision, hearing, speech, and other conditions, the school system should make the services available. (Discussed in Chapter VIII.)

c. *Further professional care from the medical, dental, and allied professions*—This group is usually the largest. Some of the children will need special school guidance programs in addition to the medical follow-up for further diagnosis, correction of defects, treatment, and supervision.

d. *Improved health behavior*—This group overlaps with group c. Each child would profit by receiving, even occasionally, the personal attention of the teacher, nurse, or medical adviser. This personal guidance would be in addition to the more formalized group health instruction. In this teacher-pupil relationship, the teacher would recognize what health habits need reinforcement and commendation and what habits could best be supplanted by more desirable ones.

e. *Mental hygiene*—This is a term often used to cover the treatment of problems of nervousness, worry, emotional unbalance, and behavior problems that are not easily accounted for by physical causes. The explanation for these phenomena, however obscure, may still be of a physical nature. On the other hand, they may be accounted for by faulty home conditions, such as lack of sleep, overstimulation, inadequate diet, too much or too little discipline, no companionship, poverty, or no play. They may be the result of worry over school situations or they may be based upon irregularities of growth or concern over sex. (Discussed in Chapter VII.)

f. *Institutionalization*—This will be needed for certain of the markedly handicapped. (Discussed in Chapter VIII.)

Whatever the problem is, it is well to have the expert advice of the doctor before jumping to conclusions and taking the chance of giving faulty advice and guidance. The source of mental hygiene problems is too often obscure. Every child is not confronted by difficult problems of adjustment. However, all children could profit by sound educational guidance. The schools must focus on methods that will avoid the setting up of inadequate and immature emotional patterns.

When a serious mental hygiene case is observed, it should be referred to the school medical adviser for disposal. Special arrangements within the class will have to be made for selected cases. The greatest effort must be made to get the child to help himself (see Chapter VII).

A shortened school day or rest periods in a comfortable, quiet place may be required by delicate children, the easily fatigued, the high-strung, the recently ill, and the occasional heart case. The undernourished, the obese, children with faulty eating habits, and the diabetic may need dietetic guidance, extra meals, or help in the selection of food. The growth of these children should be checked monthly. Where a nutritionist is available, this group could well be placed under her supervision.

The overactive, restless child may need even more play and freedom to move about than the program provides. The functional postural defects and cases exhibiting faulty body mechanics may be referred to the physical educator by the medical adviser as discussed in Chapter VI. In addition to corrections it is often necessary to make special seating arrangements for children with handicaps of vision, hearing, and speech. Simple, hygienic rules must be reinforced in regard to cleanliness, adjustment of clothing, taking off coats, putting on rubbers, avoiding drafts, overheating, chilling, putting hands into the mouth, picking the nose, and the like. Mental hygiene cases should be reviewed by the psychological guidance clinic. The findings of the psychologist will be of great advantage to the medical adviser in his appraisal of the situation.

The clinical psychologist has the advantage of a battery of tests at his disposal. Some of these tests will aid in determining the intelligence and achievement of the child. Certain special diagnostic tests of reading, arithmetic, and spelling may be helpful in locating the major difficulty. Many clinics test motor development. Tests of growth and development, with the exception of height and weight, are usually carried out as special studies. Attention and ability to concentrate, memory, imagination, personality, attitudes, and special aptitudes may be submitted to testing procedures.

A few valuable principles for school health guidance are as follows:

1. Be familiar with the health liabilities and assets of the community.
2. Practice what you preach.
3. Add continuously to your knowledge of growth and development.
4. Familiarize yourself with the needs of each child by reviewing the history and the medical adviser's advice.

5. Learn to know the child as a friend.
6. Keep abreast of his ever changing interests.
7. Depend upon his interests to motivate his health behavior
8. Find occasion to talk with him alone, especially as regards his extraschool program and current ambitions
9. Get acquainted with the family and join forces to achieve results.
10. Answer all questions accurately Do not hesitate to admit your lack of accurate, up-to-date, factual knowledge
11. Freely seek accurate advice by conferring with your medical adviser, community agencies, and source material.
12. Be alert to observe day-to-day changes in appearance, attitude, and behavior.
13. Realize that it often requires professional judgment to decide whether the changes observed in the child are based on physical or mental conditions. It is easy to guess incorrectly.
14. Do not overestimate the value of any procedure.
15. Remember that the child is conditioned to a large degree by his home and community environment.
16. Recognize the fact that a child may behave one way in school and the opposite way at home.
17. Agree on objectives and methods, for to change a child's health behavior and consolidate satisfactory patterns of living the family and school must cooperate.
18. Where necessary, confer with the parents on the child's needs, for this may be the most important factor in making the indicated corrections. Educating the parents means discovering their characteristics and getting them to agree that something needs to be done.
19. Build your health instruction program around the child's changing interests and needs.
20. Be encouraging always.
21. Keep competition completely out of the health practice, for each child is a pattern unto himself.

Health Service Records

Too much emphasis cannot be placed upon the need for a complete health record system with the clerical help required to keep it up to date. The individual record is an orderly, brief accumulation of all pertinent data that are easily available, confidential, and contributed to routinely by all members of the school as the activities and appearance of the child dictate. This record should be interpreted by the medical adviser and reviewed periodically to determine the improved status of the child. Has advice been followed by the family, child, teacher, and the school personnel? Have defects been corrected? Has the school program been adjusted? Has the child gained weight? Does his work progress as expected? Is he more cooperative, happier, less conspicuous?

The form of the record is important. It is often recommended that this card be a cumulative record card. There is some question of the desirability of one cumulative medical examination card, desirable as it may seem as a device for noting changes in history and examination from time to time. Too often the attempt to get too much material on a card jeopardizes its usefulness. Space is too limited for adequate notations, even with a checklist system, and writing becomes illegible. It would seem far better to use a cumulative history card with a new examination form for each subsequent examination. The history card must not be too detailed but should carry all essential information pertinent to the child. It is important that the health record accompany the other records of the child. Some school systems provide for this by using large individual envelopes containing the school records of each child.

The school record of the child should include his personal health record, which should contain:

1. The preschool examination
2. The school health service examination (history, findings, advice)
3. Correspondence with family
4. Correspondence with family medical advisers
5. Correspondence with clinics and agencies
6. School health service; notes; reports from teachers, special teachers, nutritionist, and psychologist; and the doctor's summary
7. Nurses' reports
8. Notes of counselors and record of use made of these data for guidance purposes
9. A chronological record of examinations, tests, corrections, illnesses, and observations from all sources.

Another barrier to success has been purely mechanical and is concerned with handling the data. If a central record system is not maintained, the principal's office should have the files to maintain all data up to date and abreast of current progress in such matters as refers, corrections, teacher observations, and changes in the guidance program. Special care must be exercised so that the health records may not be used in an unprofessional way. These are confidential files and must be properly maintained and protected.

It is not always necessary for the classroom teachers to know the exact medical findings altho they must have an interpretation of the child's health status in order to make the necessary instructional adjustments. Where confidential information is made available, professional ethics should prevent teachers from carelessness which will result in harm either to the child or his family.

It is highly desirable to set up the record system so that the local data are comparable. This should not mean that at the present time research data are the criterion for the setting up of the record system. The record system should be set up on a utilitarian basis.

Variations from the Suggested Procedures

Current school health service may be considered woefully inadequate in terms of total coverage. There are not enough provisions for health service outside urban districts. Within these urban centers principal attention has been focused on the problem of annual health examinations and suggestions for immunization. Problems involving the cooperation between home, school, public health authority, practicing physicians and dentists, and community have not been carefully thought out. In the wealthier school districts good provision has been made for examination rooms and specialized, well-trained personnel. Frequently the employment of a public health nurse is the first step. Records are generally inadequate and there is little correlation between these health records and the total instructional process. Some specialized guidance exists but generalized guidance integrated within the several curriculum divisions is strangely lacking. There is much too little correlation between physical education departments, home economics, and other divisions.

How much of this total program exists currently in the public schools? If the total number of administrative areas (126,849 school districts) is taken into consideration, the general conclusion is that the great majority (some estimates are as high as 80 percent) are without any or else practice only the most rudimentary form of health service. Health service is confined largely to urban school systems. Even these urban systems are handicapped by the complexities of the problem, the areas of overlapping and conflicting authorities, the lack of cooperative planning between the school, the community health service, the practicing physician, the dentist, and the home.

With the foregoing plan as a goal, what minimal health guidance procedures should be undertaken?

1. Provide for joint planning of school program by school administrator, school medical adviser, school nurse, and teacher.
2. Select and use systematically a simple history card.
3. Encourage the teacher to test and inspect vision and hearing periodically.
4. Weigh monthly and measure height twice a year.
5. Plan for teachers' day-by-day observation of pupils and referral to physician or nurse of those showing deviations from normal.
6. Provide periodic health examinations for all pupils if possible, but where facilities and personnel are inadequate limit the examinations to those who need it most.
7. Note mental hygiene cases and develop guidance plan.
8. Survey community health assets and liabilities.
9. Use the coordinated efforts of the community as discussed in Chapter XV.
10. Provide in-service training for the teachers and maintenance staff. The county medical and dental societies and the local public health authority will cooperate in all aspects of the program.

The federal government, thru the United States Public Health Service and the Children's Bureau, is assisting the states with budget and personnel to promote health education. Consult the directory in the Appendix for further details on these services.

Possibilities in Cooperative Guidance

Some administrators have focused attention on the teaching process. Doctors have been devoted to diagnosing disease and the care of the sick. The layman has been interested in avoiding pain and discomfort and enjoying feelings of buoyancy in the hope that he may live a long life of satisfaction without the handicap of disease. The interests of these three groups must be brought into a unified plan of action if the health promotion program is to be adequate. The educator and the doctor must point the way, for the educator is familiar with school procedures, educational psychology, and methodology, while the doctor is trained in the science of health. Each must come to a clear understanding of the nature of the school child and his needs and the contributions of his profession to the perfection of the health of the school child. When this is done, a joint plan of action can be agreed upon thru which the child may be exposed to the most enlightened procedures.

After years of experience with the health problems of school children, there is no evidence to show that the doctors alone are prepared to take over the direction of the education of the child in matters of health any more than there is evidence that the educator alone is capable of directing the health practices of the child. It must be a cooperative process with the parents playing an important role. This is illustrated in the field of medical service, where responsibility must be assumed jointly by the individual, school, home, family physician and dentist, and the community.[17] Every effort should be made by the schools to educate the family in its responsibility for the protection of the child. The responsibility for medical and dental service must not be usurped by the school because of the immediacy of current health problems.

The schools, in general, have avoided undertaking medical treatment. The medical service has been limited to health examinations, consultations, and advice. The recommendations within the school are concerned with the child's program, involving shortening of the school day, adding rest, extra feedings, and indications for special classes. Every effort should be made to use the medical situation as an educational experience from which may be derived principles that will function thruout life. The child will learn discrimination regarding adequate medical care and practices in order that his health may be protected and promoted so that he can live with satisfaction.

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[17] See Chapter XV for cooperation among health agencies

CHAPTER IV

School Health Instruction Program

HEALTH TEACHING today aims at more than mastery of facts. It is concerned with the improvement of human living. So conceived, much that is called education is in reality health education, and that which is termed health instruction becomes important in every school. The goal of intelligent self-direction of health behavior by every person in our society is an ideal toward which to strive. Organization of the curriculum to provide experiences and instruction for children which will help them to develop acceptable health practices, scientific and wholesome attitudes, and understanding of sound health principles constitutes the desirable program of health instruction in the schools.

Health is so vitally a part of all living experience that it is impossible to circumscribe the health teaching program with courses, plans, and study outlines. The child gains health understandings, exhibits behavior of import to health, and develops attitudes toward such behavior in all phases of his school experience. These continuous experiences and concomitant learnings are of such importance and the understanding of their relation to all education so necessary that each teacher must become aware of her role in health guidance and teaching if the school program is to be effective in health improvement. Health instruction is the responsibility of every teacher.

It is recognized that the school provides only a part of the total experience of the child. He lives in a home in a community and has a multitude of daily experiences, not directed by the school, which affect his health behavior. The cooperative action of school, home, and community is essential if the most effective type of health direction is to be developed. In fact, there may be conflict between that which is taught or practiced at home and that which is advocated at school. The child who comes to school with patterns of behavior and belief which are contrary to health principles must be carefully guided toward improved thinking and doing, without arousing in him emotional reactions of contempt, rebellion, or doubt concerning his home. The school health instruction program must be but one phase of a broader health improvement program involving all groups and agencies which touch the life of the child.

Realizing these relationships, this chapter will attempt to point out the opportunities for improvement of practices, beliefs, attitudes, and knowledge to be found in the school health instruction program. Administrators are prone to voice a recognition of need for such a program and then to ignore it when curriculum planning and program scheduling are under way, allowing no time for it and providing no trained teachers. Opportunities for healthful experiences and the development of health understandings should be as carefully provided as any other phase of the school curriculum. Organization for health instruction is an outstanding need in the schools today, and the responsibility for such organization rests squarely on the shoulders of the administrator. These leadership responsibilities are discussed in greater detail in Chapter II.

Health Instruction in the Elementary School

If it is agreed that the measure of success of health instruction is its influence on the behavior of the child, then it is readily seen that emphasis on facts and knowledge is of subordinate importance to the development of desirable practices, attitudes, and understandings, particularly in the elementary-school child. Knowledge functions as it bolsters practice or makes it intelligible. Health instruction in the elementary school is primarily a matter of helping the child to live most healthfully each day and to learn to meet changing situations in a healthful manner. Health instruction thus becomes an aid to a way of life rather than a subject to be taught.

Such a concept, if truly grasped, would result in a continuous health instruction program thruout the school day in connection with all activities, and the designation of a specific period in the daily program for health teaching as such would be unnecessary. Unfortunately, such an ideal is difficult to attain in practice. Many schools and teachers are still subjectmatter-conscious to the degree that unless a period in the school day is set aside for health instruction it will be almost completely neglected. Certainly, in all those schools where the curriculum is based directly on the needs and interests of children and is really functioning on this basis, there will be little or no necessity for a time requirement for health instruction. Possibly the questions listed at the end of this yearbook will be helpful in appraising the effectiveness of the health program.

The nature and content of the health instruction program for elementary-school children should be determined by the needs and interests of the particular group and by the accepted developmental standards for children of about the same maturity. No set course of study can be prescribed which will fit the needs of all groups or of all children, but a guide may be of value to the teacher in charting the course of her group in accord with standards recognized as being important for similar groups of children. State and local courses of study can be of most value if they embody the results of group thinking and experience directed to this end, together with suggestions as to the means of discovering the needs in a particular group and methods which have been used in meeting these needs.

Knowledge of the developmental and behavior needs of all children indicates that health teaching in the elementary school will center around the formation and extension of desirable practices, attitudes, and understandings associated with (a) nutrition and growth, (b) relaxation, rest, and sleep, (c) activity, (d) fresh air and sunshine, (e) elimination, (f) cleanliness and care of teeth, body, and clothing, (g) importance of and means of securing dental and medical attention, (h) control of infection, (i) care of eyes and ears, (j) posture, (k) safety, and (l) emotional and social adjustment. In the upper grades of the elementary school there is, in addition, need to widen the horizons of the pupils to introduce them to health problems of the home, school, and community. These problems should not be considered in any predetermined sequence but should be more or less constant concerns of the teacher as she works with children and discovers their needs and interests. The scope and extent of the consideration of any particular problem will depend on the age and maturity of the children. As the child gains maturity he gains in capacity for understanding the reasons for health procedures and in ability to solve problems related to them, and should be given opportunity for the development of such understandings.

How, then, can the needs and interests of a particular group of children be discovered and charted as a basis for the selection of content for that group? Sources of such information for teachers are to be found in:

1. *Knowledge of the social, economic, and cultural background of the community and of the child*—Obviously a program adapted to the needs of a child of foreign extraction in a mining town will not fit the child from an isolated ranch home on the prairie or one from the home of a professional man in a metropolis. Nor will it be of value to teach safety principles for urban areas in a one-room school in the mountains The setting of the child gives the first clue to his needs, attitudes, and understandings
2. *An understanding of the individual health condition of each child as revealed by the results of the health appraisal, records of illness, and observations of behavior*—Both individual and group health needs come to light by a study of the health record cards Each teacher should be familiar with such records for her group. Additional records are often available which reveal mental and emotional needs. These, too, should be used as a basis for development of the health instruction program for a particular child or group.
3. *Observations of behavior*—The child reveals his health habits and attitudes constantly in his everyday action. The teacher can observe and note behavior in relation to cleanliness, posture, food, activity, use of eyes, control of infection, safety, and emotional and social adjustment Helping each child to improve his behavior is the goal of health teaching. Certainly an understanding of his daily actions is necessary as a starting point.
4. *Expressions of child interest*—Thru daily contact with children the teacher discovers their interests and, if wise, utilizes them to teach health principles as well as to lead them on to the development of additional interests. For example, interest in a playground accident may be the initial factor in the development of a comprehensive safety unit which leads the child on to interests not inherent in the original incident.
5. *Tests of health knowledge and attitudes*—For upper-grade children particularly, knowledge and attitude tests can be used to discover strengths and weaknesses in their health background. Such tests should be diagnostic in nature and can be of value in planning the health instruction program A list of available tests of this nature is to be found in the Appendix section on methods of appraisal of school health programs

These, then, are some of the ways of discovering needs and interests. Such material should be compared with the accepted developmental standards for similar groups and an effort made to lead children on from their present status to improved understanding and practice. Some interests may never develop accidentally. It is the business of the teacher to use the interests which are present in a child or a group to lead on to wider horizons of experience. With such a basic concept, the health curriculum becomes a vital, developing, changing force in the guidance of children in improved living.

Primary Grades

Particularly in the primary grades, health instruction should be thought of as a way of helping children to live healthfully at home, at school, and at play. It is questionable whether any particular period should be set aside for health instruction, but every effort should be made to direct teachers so that they will become conscious of the health opportunities and implications in all their teaching. In the primary grades health teaching can be most effectively accomplished thru (a) the utilization of daily experiences for guidance in health behavior, (b) stimulation of the practice of health habits, (c) development of understanding of the environments and the activities of people, and (d) the use of health readers and creative expression. The extent to which each method is used will depend upon the needs of the group, the availability of materials, and the understanding of the teacher.

Utilization of daily experiences—Opportunities for guidance of boys and girls in their daily living experiences are numerous. A few illustrations of typical school experiences replete with opportunities for health instruction are indicated.

1. A unit on safety may easily develop from the necessity of training in safe practices going to and from school, or from the occurrence of an accident in or near the school.
2. The morning inspection should lead to consideration of problems of illness and personal appearance. Care should be exercised to insure that children will not be embarrassed before the group if they fail to meet standards of personal cleanliness
3. Checking the roll may lead to inquiry concerning causes of absence and a consideration of means of reducing absence due to illness.
4. The school lunch offers many opportunities for training in cleanliness, food habits, manners, and desirable social experience. The educational outcomes of the school lunch are sometimes of as much or more significance in the lives of children as the actual nutritional benefit accruing from consumption of food The properly conducted school lunchroom will be a factor in training children to wash their hands before eating, to eat and like a variety of foods, to sit down to a leisurely meal, to practice good table manners, and to converse with others. The school lunch offers an unexcelled opportunity for health instruction.
5. The weighing and measuring program can be the source of many health learnings. Children are and should be interested in growth, and concern for growth is one reason for the institution of weighing and measuring procedures. Interest in things which help children grow will be motivated by growth records

kept by the individual child. The old practice of classifying children as "overweight" or "underweight" on the basis of height-weight-age tables has been abandoned because of the many false interpretations put upon such data. The important thing to discover about each child is the fact that he is or is not growing, using this information to encourage health performance favorable to growth.

6. Rest periods are desirable for younger children and should be utilized to teach relaxation. It is important that floors should be warm and free from drafts if children lie down on them, and that clean mats, rugs, or papers be used to protect clothing. Relaxation while seated in chairs or at desks can be taught if it is impractical to use the floor.

7. Learning to use toilets, wash bowls, and drinking fountains correctly presents many opportunities for health teaching.

8. The health examination, dental appraisal, audiometer testing, immunization program, and tuberculosis testing procedures are sources of many health learnings. Children should know what to expect, how to conduct themselves, and the reasons for such procedures as far as they are capable of understanding them Discussion should both precede and follow such programs, and attention should be paid to the development of desirable attitudes and understandings in connection with them.

9. The use of books and materials involves problems related to the use of the eyes, lighting, and cleanliness.

10. Adaptation of clothing to weather conditions is an important consideration as weather changes. Wearing coats, rubbers, galoshes, and snow suits for protection outside in stormy, cold weather and removing them indoors is important. The use of short hose in cold weather is a special problem Children need to be guided in behavior in regard to clothing.

11. Play periods offer opportunity for experience in desirable exercise habits, safety skills, enjoyment of fresh air and sunshine, desirable emotional expression, and social adaptation. If the play or recess period is to be an educational experience, it must be planned, organized, and directed by pupils and teachers working together. The positive experiences noted are just as possible on the playground as fights, quarrels, poor sportsmanship, swearing, and accidents. Planning and leadership make the difference.

Stimulation of health practices—Because of the fact that health behavior is important at home and at play as well as at school, efforts have been made to stimulate children in the performance of health practices. Many devices have been used—some of them good, some questionable. Any device for checking health-habit performance which encourages dishonest reporting in order to secure approbation of teachers or classmates should be abandoned. Gold stars and similar motivations are seriously questioned because of their effect on child attitudes. Methods which might be used to stimulate health practices if efforts are made to keep them educationally sound are noted.

1. Informal morning inspections may be used to check on cleanliness. Such inspections should be conducted by the teacher and not by children This check may be made at the same time as the inspection to discover signs of illness.
2. Attractive posters or charts illustrating "Things We Should Do" may stimulate interest in performance.
3. Individual health-habit checking devices may interest the child in improving his performance. These should be used as competitive devices only as far as a child is encouraged to compete with his own record.
4. Quiet commendation of children for desirable performance brings satisfaction to them. Children are interested in pleasing the teacher and in being accepted and approved by other children. This natural desire can be utilized in some instances to improve health behavior. Commendation should be expressed quietly to the individual child, so that embarrassments and conceits may be avoided.

Understanding the environment and people—In the primary grades an effort is made to help the child to explore, understand, and adjust to his environment and to the people who touch his life. In the study or exploration of any phase of the social or physical environment, health considerations are of importance. Experiences in these grades will include studies of milk, water, food, housing, clothing, pets and other animals, plants, transportation, industries, and many other problems, all of which have important health implications. The alert teacher will do much health teaching as she helps children to become acquainted with and to solve problems concerning the world in which they live. There is no need for labeling such teaching "health instruction," but it is important to recognize the value of this method of approach.

Use of health readers and dramatic expression—Health readers which are educationally sound may well be placed in the primary-grade library to be used as supplementary reading material. Readers and stories chosen should avoid the fantastic and unreal, emphasizing instead stories of real children participating in real experiences. Health fairies, personified vegetables, and talking toothbrushes are not conducive to the development of the most wholesome attitudes and concepts.

Dramatic and rhythmic expression may be encouraged, using real or probable experiences as a basis for pantomimes, plays, rhythms, and stories. Rather than searching for printed material in this area and training the children in its performance, it is considered more worthwhile to help children in the creation of their own dramatic and rhythmic activities. Such experiences are helpful in developing desirable attitudes if they are skilfully guided.

Intermediate Grades

The health instruction program of the intermediate grades will in most respects be similar to that suggested for the primary grades. Guidance in daily living, recognition of the health aspects of other curriculum experiences, reading, dramatic expression—these are continuing methods to be used thruout the elementary school. In addition, the older child has need for more information, more understanding, and more knowledge. He needs to know more of the "why" of health behavior and to be able to solve problems arising from the need for adaptation of behavior to changing situations. Continued emphasis on health practice and health attitudes is needed, but these do not constitute the whole program.

Whether or not a specific period of health instruction as such should be provided in the intermediate grades depends on the organization of the school. Those schools operating on a flexible schedule will provide for consideration of health problems as problems arise and needs become evident. Those whose schedules are more fixed will find advantage in designating a period for health instruction. Whatever the type of organization, opportunity for improving the health practice and understanding of every child should be consciously provided. Flexibility in scheduling should result in integration, not in neglect.

It is important that in the attempt to teach more of the factual background of health behavior the material used shall be that which meets the needs and interests of the particular child or group. As soon as a health teaching program begins to concern itself with knowledge, there is a tendency to emphasize the technicalities of body structure and function without reference to the developmental needs and interests of children. Facts which have meanings for children in the terms of their experience should be taught.

Another observation of significance is that there is need for a graded program of instruction thruout the intermediate groups. It is recognized that the health teaching program will continue to center around the same areas as it did in the primary grades, but the material for health classes for older children should be adapted to their level of intelligence and understanding, challenging them to thought and action. Teaching the same concepts and conning the same health rules year after year will develop in children a widespread dislike for "health classes." They want to hear and know more than is included in "The Rules of the Game" or similar elementary concepts. Conversely it is important to avoid teaching material beyond the level of their development. A practical knowledge of the body and its working is necessary, but the technicalities of anatomy and physiology have little place in the elementary school. Even in the high school such technicalities have little or no meaning unless they are directly connected with the problems and interests of pupils.

There is need for the inclusion of many activities, projects, and problems in the health instruction program at this level. Finding out how and why things work as they do, evaluating and rationalizing individual and group practice, planning and executing practical projects—these capture the interest and enthusiasm of children and are the most effective means of learning. Thru such activities children come to know and to be intelligent concerning health problems of the individual, the home, and the community.

The opportunities for correlation of health material with other school areas of experience are many, and the alert teacher will recognize and utilize them. Other possibilities are given in Chapter V. No attempt should be made to inject health concepts in an artificial manner, but certainly opportunities which are inherent in subject-matter and activities in other fields should not be neglected.

Social studies

1 Study of food supply, housing, clothing, community services, recreation, transportation, inventions, and disease problems of people of this and other countries
2. The local community, its health services and problems
3. Health conditions of past generations and cultures.

Science

1. How animals and plants grow, develop, and reproduce, and the factors which favorably and unfavorably influence these life functions
2 Microscopic life and the role of disease-producing organisms—nature, spread, and control
3. Appreciation and love for the out-of-doors.

Language arts

1. Health experiences and problems for written or oral discussion
2. Child-planned dramatizations
3. Health articles for the school newspaper
4. Stories and poems which favorably influence attitudes concerning many aspects of living.

Art

1. Posters, borders, murals, illustration of individual health records

Physical education

1. Safety in physical activities
2. Adaptation of activities to individual health conditions
3. Mental and emotional values in participation in wholesome activities
4. Posture and feet conditions.

In schools where the activities, experiences, and interests of children are the bases of the curriculum, health activities will be an integral part of the total picture. In programs of curriculum construction there is need for a recognition of the health relationships. Any curriculum which is concerned with the total growth and development of children will not neglect the health aspects.

Selection of Materials for Health Instruction

The materials used in health instruction vary widely in nature, and the choice of materials depends upon the particular activity or unit of instruction.[1] Effective health instruction programs depend to a certain extent upon the wise selection of materials, and teachers often need help in making a selection. The materials used may include books, magazines, newspapers, bulletins, stories; audio-visual aids, such as charts, models, posters, graphs, motion pictures, slides, radio; construction materials for scrapbooks, murals, charts; and environmental materials to be found in the home, school, and community.

The most important criterion upon which to judge the worth of materials is their effect on the attitudes, information, and behavior of the child. More specifically, criteria which may be used to evaluate health materials include the following:

1. Are the materials scientifically sound? Is the subjectmatter valid and is it presented in such a way that it will facilitate learning?

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[1] For further suggestions consult: National Education Association and American Medical Association, Joint Committee on Health Problems in Education. *Health Education.* Washington, D. C.: the National Education Association, 1941. Chapters 8, 9, 10, and 11, p. 177-295

SCHOOL HEALTH EXAMINATIONS—*When the child first enters school the thoro physical examination, with a parent present, lays the groundwork for future cooperative plans. Disabilities which have not been corrected during the preschool period should receive attention at this time. On the basis of the information obtained the school can deal intelligently with the individual nature and needs of the child.*

Photograph by
St Louis (Missouri) Public Schools

2. Do the materials make provision for individual needs and differences? Are they flexible in their application?
3. Do the materials selected provide for progression in activities and concepts? Is there opportunity for growth?
4. Are the materials related to the experiences of children in such a way that they assume significance in their thinking and behavior?
5. Are they attractive and hygienic? Do they conserve vision? Are they easily cleaned?
6. Do they have real educational value and not merely entertainment appeal?

In the selection of materials for health classes, teachers are always faced with the problem of the use of materials from commercial sources. Many companies publish charts, bulletins, pamphlets, and posters which are available to schools free of charge. Much of this material is sound; some of it is questionable. Teachers must abide by the policy of the school in which they teach and if such sources of materials are prohibited, abide by the ruling. If commercial materials are permitted, a qualified committee should evaluate them and recommend those suitable for school use. Organizations from which materials may be secured are listed in the Appendix.

Things To Avoid in Health Teaching

The interest of schools in health and the sincere attempts to establish programs which will be helpful have given rise to many fine practices but have also resulted in some questionable procedures. In order that teaching programs may develop along lines which are educationally sound, a few cautions are advisable. Things to avoid in health teaching are summarized in the following statements:

1. Artificial rewards are unsound sources of motivation for the performance of health habits. They may stimulate dishonest reporting, create antagonisms within groups, and attach value to the reward rather than to the performance.

2. Children should not compete in health-habit performance. Some children are handicapped because of home conditions or their own health status and cannot compete on a fair basis. Furthermore, antagonisms and dishonest reporting are probable outcomes.

3. No child should be made to feel conspicuous or inferior by calling attention to his health condition in the presence of other children. Crippled children, overweights, underweights, and other deviates should not be subjected to any special comment.

4. Children should not be expected to meet standards which are impossible because of home conditions. For example, many children cannot have a quart of milk each day because their parents cannot supply it.

5. It would be well for teachers to avoid talking to young children about health in abstract terms. They are interested in growing or in being big and strong but they are not interested in abstract health meanings.

6. Every effort should be made to avoid emphasis on the morbid, the abnormal, or the fearful. Health, life, and growth should have happy connotations for all.

7. Dogmatic statements in respect to health practice should be avoided. Each individual is a unique organism whose needs vary according to his own particular make-up. It is granted that all have basic needs in common, including food, air, water, elimination, activity, sleep, and protection from weather and disease, but in meeting such needs adaptation to individual differences is essential. All children should not and do not eat the same amounts or kinds of food, sleep the same number of hours, have the same eliminative rhythms, require the same amount of activity, need the same number of glasses of water, or weigh the same number of pounds. Basic concepts and accepted practices should be taught, but not as dogmatic rules which cannot be altered or adapted to individual needs.

8. Nursery rhymes, songs, and good literature should not be parodied to "teach health." By so doing, finer appreciations may be destroyed.

9. The teacher who is a poor example to children should be willing to alter her health practices so that she may exemplify her teachings.

10. Teaching which is above or below the intellectual level, or which is far removed from the interests of children, should be abandoned. Every successful health teaching program is based on the needs, capacities, and interests of the individual group.

Many other suggestions for health instruction will be found in the publication *Health Education*[2] and in "A Report on Health Teaching" (December 1941 *Journal of Health and Physical Education*, p. 556-57, 587-88). Consult also the bibliography given in the back of this yearbook.

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[2] National Education Association and American Medical Association, Joint Committee on Health Problems in Education, *Health Education*, *op. cit.*

Secondary-School Health Instruction Program

The organization of health instruction in the secondary school has long been a problem. While recognizing the need for such instruction for the adolescent, administrators have been hesitant to organize their curriculums and schedules in order to provide it. Consequently, health teaching has become the responsibility of first one department and then another until in many schools it has little or no status. There is need for a well-defined policy in regard to health teaching on the secondary level. Administrators need to become increasingly conscious of this need and to formulate and follow a positive policy in regard to it.

The fact is recognized that health concepts and materials are contained in science, home economics, physical education, and social studies courses. The contributions of these areas are discussed in Chapters V and VI. Experience has shown that if no additional instruction is provided beyond the "accidental" correlated material in the courses indicated, the health instruction program is usually inadequate. There is a need for a *required* health instruction program in both junior high- and senior high-school divisions.

Organization for Health Instruction

The most important single factor in organizing for health instruction in the secondary school is the employment of a teacher trained in the health sciences and in health education to direct the program. Good teaching in this area is made prominent by its scarcity, and on good teaching the success of the program depends, no matter what type of organization is used.

Possible administrative arrangements to provide a required health instruction program in the secondary school are as follows:

1. *Separate health instruction courses may be established and required of all pupils*—The plan of separate courses has particular merit in the senior high school and is recommended as the most effective means of providing an adequate program. Physiology or human biology is at present included in most high-school courses of study. Such a class can be broadened in scope and vitalized so that it includes a variety of human conservation problems, both personal and public, with physiology and anatomy serving as a background of explanation for some of these problems. The emphasis should be

shifted from bones and blood vessels to problems of living. Concepts of racial improvement, public health, and adequate personal and social living are the sources of curriculum materials. Such a course is most profitable in the junior or senior year in high school. It should meet daily for at least one semester, preferably for two, and be recognized as on a par with other school offerings. The course might be called "Problems in Human Conservation," "Human Biology," "Personal Living," or something similar.

In the junior high-school division it seems less desirable to confine the required health course to one year or one semester. An ongoing program of health instruction can be provided thruout the three years of the junior high school on a two-day-a-week basis, alternating with some other subject. This course needs to be definitely coordinated with the work being done in science, social studies, and physical education so that a unified, nonduplicatory program will result.

2. *Health instruction may be conducted in connection with physical education classes on an alternate day basis*—Holding such instruction only one day a week is not profitable, but if given at least twice a week it can be of value.

Advantages of teaching health and physical education on an alternate day basis are to be found in (a) the administrative advantage in scheduling classes where more than one group must use the gymnasium the same hour (one group can be scheduled for the classroom while the other is in the gymnasium and then alternated daily); (b) the fact that physical education teachers are in an excellent position to know the health needs of pupils; (c) the nature of physical education programs and the possibility of making them laboratory periods for health practice in posture, use of feet, exercise, safety, cleanliness, training rules, and emotional habits; and (d) the fact that the sexes are naturally segregated and certain phases of body development can be more easily considered in separate groups.

Disadvantages of such an arrangement are to be found in (a) the negative attitudes of some pupils toward health instruction when they feel that they are being deprived of their physical activity in order to study health principles; (b) the attitude of some physical education teachers who consider health instruction to be a burden instead of an opportunity; (c) the fact that classes are often too large for successful classroom teaching; (d) the lack of classrooms, books, materials, and other teaching aids; and (e) the fact that many physical education teachers are not qualified to teach health education. Most of these disadvantages can be obviated with good scheduling, adequate planning, and excellent teaching. The administrator has a responsibility in providing the situation in which such a program can work successfully.

3. *Health instruction can be made a part of the general science curriculum in junior high school if the science teacher is trained in health education*—If science is taught each year, certainly health instruction can be included in the course of study. In some schools, science is taught for one semester and health for the other. The more desirable arrangement would be to integrate health instruction units thruout the science course (see Chapter V). If this latter plan is followed, care must be exercised to insure the inclusion of an adequate health instruction program. Some science teachers become so concerned with the technicalities of their subjectmatter that they pay little attention to the health needs and interests of boys and girls.

Whatever method of organization is used, the instruction in health principles should be more than a makeshift and an incidental affair. There is no course given that is of more importance in helping children to improve their living. For that reason such classes should be given every advantage so that they may succeed. The practice of holding hygiene classes in the gymnasium or auditorium should be abandoned. Classes should meet in classrooms, be no larger than those in other classroom groups, be allowed credit on a par with other school subjects, and be provided with texts, references, charts, slides, models, moving pictures, and similar instructional aids. Teachers trained in the health sciences should be employed to direct such courses.

The course of study needs to be carefully planned to avoid duplication and to meet the needs, interests, and capacities of the particular group. The content of such courses might well include many phases of personal, home, school, and community hygiene, including nutrition, respiration, excretion, exercise, rest, play and recreation, mental hygiene, social relationships, personal care, disease and disorder, alcohol, tobacco, drugs, community and industrial health, safety and first aid, preparation for marriage and parenthood, heredity, eugenics, or any other subjectmatter in the field of hygiene that may be important to the individual or to the community in which he lives.[3]

The selection of subjectmatter for any particular group will depend upon interests, needs, and backgrounds. Discovery of health needs can be made by studying health examination records and by observing health behavior, as well as by becoming acquainted with the social, economic, and cultural background of the group. (See material in preceding section on "Health Instruction in the Elementary School.") Knowledge needs are evidenced thru an analysis of the results of an adequate health knowledge test and thru a survey of the informational background supplied in other courses. Health interests may be discovered thru awareness of the questions and expressions of pupils in daily contacts with them and by asking them to submit or check a list of health topics or questions in which they are interested. If awareness of pupil needs and backgrounds is the first concern in selection of subjectmatter, health courses will become more functional.

If health classes are taught each year, care must be taken to see that the same general areas are not emphasized too often, or pupils will become weary of repetition. For example, in the junior high-school division, personal health problems may be emphasized in the seventh grade, community problems in the eighth (or vice versa), and first aid and safety in the ninth. This arrangement need not exclude consideration of pertinent problems outside the particular area if need or interest arises for taking up some other material related to a particular situation or problem. Flexibility is to be desired in the choice of material, but boring repetition is to be avoided.

Methods

The conduct of hygiene classes does not differ materially from the method used in other courses. The choice of methods will vary with the size and maturity of groups, available source materials, teaching environment, and the training and experience of teachers. More desirable methods which may be employed are discussed briefly in the following paragraphs.

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[3] Moss, Bernice, and Orion, W. H. "The Public School Program in Health, Physical Education, and Recreation." *Journal of Health and Physical Education* 10: 435-39, 494, October 1939.

1. *Discussion*—Pupils in secondary schools will gain much from well-conducted discussion. General group discussions led by the teacher or the division of the class into small discussion groups under student leaders will prove profitable. Panel discussions are interesting and can be used occasionally.

2. *Activities and problems*—Activities growing out of interests and the solution of problems arising from discussion or reading give pupils an opportunity to work in real situations. This method of teaching is usually productive of increased interest and application on the part of the pupils. It aids the teacher in breaking away from formalism in instruction and is helpful in building initiative and self-direction in pupils. Projects should be carefully chosen and planned, and pupils should be allowed freedom in carrying them thru to completion. They may be either group or individual in nature and several may be going forward simultaneously in the same class.

3. *Provision of scientific material*—Books, pamphlets, magazines, and monographs should be made available to pupils. These should be placed in the library or classroom and utilized by pupils in working out their problems. The research attitude and procedure[4] should be developed so that pupils may learn methods of attacking problems as they arise in their lives.

4. *Visual instruction*—The use of graphs, charts, posters, slides, moving pictures, and similar visual aids adds to the effectiveness of health teaching.

5. *Special lectures and demonstrations*—It may be desirable to have an occasional special lecture or demonstration of technics given by a physician, nurse, dentist, oculist, social worker, or other qualified individual. Laboratory demonstrations are helpful in presenting certain problems to pupils. Such lectures and demonstrations should be integrated with regular class instruction.

6. *Teacher example*—The example of the teacher may be considered a method of teaching inasmuch as impressionable youth is so readily influenced by the attitudes and practices of persons with whom he associates. Young people who admire and respect their teachers often strive to emulate their behavior.

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[4] Gregg, Fred M., and Rowell, Hugh G *Health Studies, Home and Community* Yonkers-on-Hudson, N. Y.: World Book Co , 1932 258 p.

Whatever the method employed, whatever the course of study pursued, the teacher may consider her efforts successful if she has succeeded in building in youth respect and appreciation for the human organism and the life process, an understanding of the problems that confront him in building and maintaining his health, and a disposition to meet life's situations in a sane and wholesome manner.

Need for Interdepartmental Correlation

In order that the health instruction program in the high school may function most successfully, it is desirable for all departments in any way concerned to integrate their efforts. Under the leadership of the principal, representatives from science, homemaking, social studies, physical education, and health education departments should confer and plan together. In this way, undesirable duplication and serious omission may be avoided and the pupil introduced to a coordinated program of health instruction. One of the serious criticisms of the high-school instructional program in health is that often several teachers and departments are conducting programs in this area with no concern for or interest in what is being done elsewhere. While every teacher should be a "health teacher" in that each is conscious of needs and adapts her program to meet them, there is danger in having each teach what she thinks necessary without understanding the total program.

What Not To Do in Secondary Schools

Attempts to include health instruction in already crowded high-school programs have resulted in many experimental plans. Good has come from such attempts, and thru experimentation schools have gradually discovered desirable practices. Unfortunately, all have not yet discarded some of the questionable procedures. A few of these are noted, together with a few "don'ts" for teachers.

1. Herding large groups of pupils into the auditorium or the gymnasium one day a week for a health lecture is productive of little interest. Unless students are active in discovering, compiling, analyzing, and evaluating material themselves they are, at best, passively interested.

2. In many schools health instruction is allowed to become a makeshift, "bad weather" program associated with physical education.

Health classes *can* be profitably held in conjunction with physical education, but unless they are regularly held and properly taught they can do more harm than good to pupil attitudes. When a health instruction schedule has been established it should be maintained in the face of the temptation to slip outside when a sunny day comes along. Even tho the sunshine may temporarily do children more good, a serious attitude toward health classes will be of more value in the long run.

3. Prizes are sometimes given for the most healthy boy and girl or to those with 100 percent correction of defects. Such a procedure unfairly penalizes the pupil who has no chance to qualify for such recognition because of inherent body weakness or unfortunate home conditions. In addition, it glorifies the child who, thru no effort of his own, happens to be a biologically superior specimen.

4. Children should not be exploited for the sake of organization advertising. Many times an organization will hit upon the idea of holding a health contest, an essay, poster, or speech competition—not particularly for the benefit of the pupils but more often for the glorification of the organization. Groups that desire to serve children and improve their health status can do it in more substantial ways than by offering a medal or a trip to the one who achieves the peak.

5. Health facts and concepts poorly adapted to the intelligence and interests of high-school pupils are often taught. These may consist of infantile platitudes to which they have been exposed since kindergarten, or premedical anatomy and physiology far beyond their level of comprehension. Nothing is so boring to high-school youngsters or so unproductive of interest as the emphasis on the technicalities of anatomy and physiology without reference to their interests and problems. Why should we expect them to learn the names of the bones of the cranium when they are more concerned with knowing how to be attractive, to be accepted socially, to get a job, and to understand themselves?

6. Teachers should rely on accepted and scientific sources of material for the health facts and concepts which are taught (see Appendix of this yearbook). There is no field in which personal prejudice and experience, hearsay, and sensationalism are so apt to be substituted for proved facts as in this area of human living.

7. The belief that the school has met its responsibility for sex education when an occasional, isolated lecture on venereal disease

or on the "facts of life" has been provided should be abandoned. A truly functioning program aimed at the development of understandings and the social adjustment of all boys and girls is the business of the entire school and constitutes the program of sex education.

8. The teacher should not expect boys and girls to develop desirable health practices when she consistently exhibits poor practice in their presence. The intellectually honest teacher will not teach foot hygiene while wearing unhygienic shoes, talk good nutrition and lunch on hot dogs and soda pop, or preach temperance and toss off a few drinks to celebrate an athletic victory.

Special Problems

Among the many problems and concepts which are included in the health course of study are several which are likely to be sources of difficulty for teachers. A point of view concerning several of these special problems is presented.

Temperance Education

There is little question but that the physical, mental, social, and moral welfare of children and youth would be improved if they would avoid the use of alcohol, tobacco, and narcotic, sedative, and stimulating drugs. The damage which these substances inflict upon human health is difficult to estimate, but there is no doubt about its being extensive and serious. Mental disintegration, moral irresponsibility, and social maladjustment follow in the wake of the use of alcoholic beverages. The increase in automobile accidents may be partially laid at the door of alcohol. Sexual promiscuity is often a result of lack of control which follows consumption of alcohol. Crime, poverty, and delinquency are frequently associated with the use of alcohol and drugs. Young people should be made aware of the dangers involved so that they may avoid the use of harmful narcotics.

In approaching this problem in the schools, care must be taken to insure a type of instruction which will promote the desired results rather than a type which produces antagonism and negative attitudes. Scientific facts which condemn the use of alcohol and tobacco are plentiful and there is no need to draw upon unproved beliefs to bolster the case. The misuse of both narcotic and stimulating drugs can be readily proved to be harmful to human health. Pupils should be introduced to scientific fact and experiment and encouraged to draw conclusions therefrom. While emphasizing the scientific background it is well to recognize that emotions and desires largely determine behavior. It is important to help them to "feel right" about the problem. An appeal to a youngster's desire to be strong, well, vigorous, and skilled in games; to be able to get and hold a job; to become a respected member of the social group—these are important in influencing his attitudes and behavior.

Temperance education should receive more attention in the secondary than in the elementary school but should not be neglected in the latter when the need and occasion arise. Biology, health education, and social studies courses in the high school offer the best opportunities for this teaching and should be so utilized. Coordination in the program is needed, as in all health teaching. In addition to the classroom instruction, a wholesome recreational program should be provided in the school where young people may participate in desirable social experiences. The athletic program provides a particularly potent opportunity for the director to instil ideals and standards of behavior in these as in other relationships. Individual guidance should be attempted in those cases where tobacco or alcohol habits have become established. Finally, the example of the fine, clean, wholesome, and respected teacher will go far in influencing the behavior of many boys and girls.

The school should not assume complete responsibility for temperance education. If the home is not sympathetic the best results cannot be expected. More significant still are the community attitudes and situations in respect to law enforcement, roadside bars, cabin camps, cocktail lounges, public dance halls, pool halls, and other commercialized recreation establishments. Unless the community unites to provide a wholesome and safe social environment for its young people, temperance will remain an unrealized ideal. The organization of community councils which attack this as well as other social problems is a hopeful development. Only thru concerted action will such problems be solved.

Self-Medication, Fads, and Quackery

There is particular need in the secondary school to develop in pupils a scientific background and understanding which will enable them to direct their health practices intelligently and to be critical of faddists, quacks, and unsound advertising. It is recognized that much of the advertising of products important to health is honest and helpful but that some of the advertising on the radio, in magazines and newspapers, and on billboards presents exaggerated claims and an intensified emotional appeal to the desires for social approval and personal fitness as a means of selling medicines, cosmetics, dentifrices, mouth washes, beverages, and foods. Boys and girls need to be helped to discriminate between honest and exaggerated advertising in this area. Fads flourish among our people and quackery persists despite the efforts of intelligent organizations and people to counteract their appeals. Education must concern itself with such problems.

Self-medication is a practice indulged in to varying degrees by practically every individual. Minor injuries and ailments may not always require medical attention. However, even minor ailments are sometimes the danger signals of more serious disorders, and the individual who prescribes his own treatment may delay diagnosis and effective treatment by so doing. Certainly, continued self-dosing is a dangerous practice and should be condemned because (a) it delays correct diagnosis and treatment, (b) it builds a false sense of security, (c) it may be an expression of excessive concern over minor or imaginary ills, (d) it is costly when rated on the basis of results secured, and (e) it often results in taking harmful drugs and preparations into the body.

The widespread and constant use of proprietary remedies is a universal American problem. Laxatives, headache remedies, sleeping powders, kidney remedies, obesity cures, and preparations for diabetes, epilepsy, and women's diseases are to be found in the medicine chests and on the pantry shelves of millions of homes. Their effects are often harmful, often absolutely useless, and may be dangerous in that they become a substitute for effective aid.

Fortunately the vast bulk of cosmetics, mouth washes, dentifrices, and similar preparations on the market are harmless in their effects. There are a few cosmetics which may prove harmful, but attempts are being made to bring them under effective control. Dentifrices, mouth washes, gargles, and deodorants are often highly overrated by their advertisers and the effects claimed for them out of all reason, but most of them are not dangerous. The price paid for many such preparations may be an unwarranted drain on the family budget.

Fads in diet, exercise, clothing, exposure to sunlight, and other practices affecting health come and go. Young people should be helped to evaluate the claims of faddists on the basis of scientific knowledge. They should be so grounded in the fundamental principles of human health and conservation that they will not be gullible believers in exaggerated claims of any type. Health is the result of a variety of factors and influences properly integrated into living, and no one rule or principle can constitute the sole means of attaining the goal.

The existence of health cults and quackery cannot be overlooked. It seems that some people are always looking for short cuts to health, for a cure-all type of procedure, for bizarre and unusual treatment. Some shrink from the realities of correct diagnosis and treatment and seek retreat in promises and procedures that do not involve pain or risk. Why, how, and where to seek effective professional aid for illness and disorder should be a part of the curriculum in every secondary school.

Sex Education

The problem of orienting each generation of young people to the aspects of human living which have to do with the relations of the sexes is one which constantly faces society. The scope and nature of these relations are broad and varied, including attitudes and conduct associated with personal development, friendship, courtship, marriage, and parenthood. Sex education is not a subject to be taught, a set of facts to be learned. It is a program of living together, a phase of education of the total personality of the child. "It means instruction, of course, but far beyond that it is a comprehensive and progressive process of education calculated to bring about the socially desirable adult attitudes and practices necessary to insure homemaking, the establishing and building of families."[5]

The need for guidance in this area is indisputable. Changing moral standards and customs, increased freedom from adult restraint, changing social conditions with respect to employment of women, marriage, divorce, size of families—these are but a few indications of need for guidance. The young person wants to understand his body development, feelings, and desires, to adjust himself to his group and its customs. The need is evident. Society must attempt to meet it thru the right type of education and guidance in the home, the school, and the community.

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[5] Gruenberg, Benjamin C., and Kaukonen, J. L *High Schools and Sex Education* Federal Security Agency, U S. Public Health Service, Bulletin No. 75. Washington, D. C Government Printing Office, 1939 p. XIII.

It is evident that the school must assume an increasing amount of responsibility in this area if the need is to be met. The school cannot do it alone, but working with the home and other community agencies it can provide leadership and direction to the program. Cooperation and understanding are essential to the establishment of a sex education program. Parents are usually not only sympathetic but anxious to have the school assume the leadership, but in order for them to support the school as well as to carry on an effective program in the home, their interest and help must be enlisted. Parent study groups, lectures and discussions in meetings of adults, coordinating community councils—all open the way for better understanding and cooperative effort.

The effective sex education program is continuous thruout the life of the child. The home, community, elementary school, and high school make their contributions. In the elementary school there is need for the development of wholesome attitudes in regard to sex as well as the establishment of a foundation in factual knowledge. It is in the high school, however, that the emphasis needs to be placed. The problems of the sex aspects of living are more acute during adolescence due to the physiological and psychological stage of development then existent. In any sex education program, knowledge is not to be considered the sole or major aim. Knowledge of biological processes is necessary, but it alone will not suffice. Emotional attitudes, ideals of behavior, understandings of social forces—these constitute the mainsprings of action. Facts are important, but interpretation of facts to build ideals of behavior is even more essential.

The many phases of the sex education program cannot be discussed here.[6] That phase which is more directly related to the health instruction program merits some comment. In health education, biology, and physiology courses consideration can be given to topics such as developing into maturity, reproduction, embryonic development, heredity, ductless glands, and venereal disease. This latter topic should be taught as a phase of communicable disease control and disassociated from the other problems noted. Problems of a more personal nature, such as bodily changes, menstruation, seminal emissions, and intimate relations between boys and girls, need to be considered in unmixed classes, usually in connection with the physical education program. There should be opportunity for discussion and questions from pupils.

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[6] For a splendid consideration of sex education in the high school, readers are referred to Gruenberg, Benjamin C., and Kaukonen, J L., *op. cit.*, 110 p

Contributions of homemaking, social studies, and language arts courses are significant and should be correlated with hygiene, biology, physiology, and physical education. In the latter department there is an excellent opportunity for informal and individual consideration of many personal problems. The physical education teacher is in a particularly strategic position to help pupils because of the informal contacts and opportunities to observe individual needs.

The personality and understanding of the teacher are perhaps the most important factors in the success or failure of teaching in this area. Teachers who attempt to give guidance in the sex aspects of human living should be emotionally mature and have a balanced attitude toward life; should have a sympathetic understanding of the problems and feelings of boys and girls, approaching their problems with insight and judgment; should be persons of good character, exemplifying only the highest type of behavior in their own living; and should have an educational background which fits them for this work. Poise, judgment, balance, frankness, understanding, knowledge, and sympathy are needed to insure positive teaching results in sex education.

As in temperance education, the school cannot do all that is needed. Even tho the school supplies teaching, guidance, and a good recreational program, undesirable conditions in the home and community may result in undesirable behavior. Coordinated effort on the part of all people and all agencies touching the lives of children is of paramount importance.[7]

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[7] American Association of School Administrators *Education for Family Life* Nineteenth Yearbook. Washington, D C.: the Association, a department of the National Education Association, 1941 368 p. ¶ Folsom, Joseph K. *Youth, Family, and Education*. Prepared for the American Youth Commission. Washington, D C.: American Council on Education, 1941. 299 p. ¶ Goodykoontz, Bess, and Coon, Beulah I., co-chairmen. *Family Living and Our Schools* Sponsored by the Department of Home Economics of the NEA, the Society for Curriculum Study, and the U. S. Office of Education New York· D Appleton-Century Co., 1941. 468 p.

Safety Education

There are certain aspects of the safety education program which lend themselves to coordination with health instruction. In many schools the health and safety curriculum has been worked out as a unit, and safety concepts and activities are included thruout the entire span of the health instruction program. In other situations safety has been taught as a separate subject or correlated with other courses of instruction, including social studies, science, industrial education, physical education, language arts, and home economics. Whatever the method selected, safety education has an important place in the curriculum offering of every school.

The aspects of safety instruction which are most readily and logically taught in conjunction with health classes are those which relate to personal safety practices, first-aid procedures, and certain community safety problems. Industrial safety, fire prevention, flood control, driver education, and certain aspects of traffic safety can better be taught in connection with other courses. Health classes should not assume the complete responsibility for safety instruction but should logically include many important phases of safety education within the scope of their work.[8]

Adult Education

If the health program for children is going to bring positive results, it must become a cooperative enterprise which enlists the best efforts of all persons in the community. Citizens, parents, and schools must work together for the improvement of opportunities for healthful growth and development of children; in order to be able to do this, opportunities for adult education are of especial importance.

Thruout the United States there is a growing program of adult education being sponsored by both public and private agencies. Parents are becoming increasingly interested and concerned with problems affecting their children and are welcoming opportunities provided in this area. Schools can be centers of functional adult education programs for parents in several ways, a few of which are indicated.

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[8] American Association of School Administrators *Safety Education* Eighteenth Yearbook Washington, D. C. the Association, a department of the National Education Association, 1940. 544 p.

1. Forums, lectures, adult classes, and study groups for parents can be organized, centering around the understanding of the child, his growth and development, his needs and interests, and means of providing the environment and guidance which will result in improved living for all children. Such groups may meet at the school under competent leadership or may be organized in neighborhoods on a more informal basis. They should give parents an opportunity to meet and discuss their problems as well as to receive instruction from trained people.

2. Community councils may be organized which are concerned with studying the health needs of children in the community and developing programs and procedures to meet such needs. Again, leadership is important and such a council may be the center of an educational program for all adults, particularly parents. The school is often the force behind the organization of such community planning groups.

3. General public health education may be conducted thru the use of the radio, the newspaper, special exhibits, bulletins, leaflets, and similar materials. This type of activity is more often the responsibility of local and state departments of health, but certainly the schools can employ similar technics in reaching parents concerning the health problems of their children.

4. Parents may and should be invited to the school to participate in health activities centering around their children. The health appraisal of the child should be interpreted to the parent. Immunization and tuberculin testing programs depend upon parental cooperation for their success. If parents are invited to help plan for these activities instead of just being told about them after they have been organized, a more wholesome and cooperative relationship will exist between home and school.

5. Visiting nurses and visiting teachers who go into the homes can do much to help parents to understand better the needs of their children and to organize their living so that these needs are met. In the final analysis it is the individualized approach to the problem of adult education which probably bears the most marked results. Such relationships between home and school must be friendly and cooperative if good is to result from them.

The school can do much to bring the parents and all other adults into its program of helping children. Only thru the development of an interested, informed citizenry cooperating with public health agencies and with the schools in their efforts to improve human living can real progress be expected.

CHAPTER V

Health Instruction in Related Areas

IF EACH SUBJECT OR AREA of school experience is to contribute to health education, three fundamentals must be provided. First, the superintendent of schools must make it clear thru statements of policy and thru administrative organization that cooperative health instruction is desirable. Second, the course of study bulletins must provide illustrative materials, units, and purposes designed to promote health. Third, principals and supervisors must provide a continuous program of encouragement and assistance that will help teachers in the related areas to contribute to the health program.

Possibilities of Cooperative Health Teaching

Once the administrative policy and organization have given the proper cue, teachers will readily find in the school program many opportunities for cooperation within and among the various subject fields or grade levels. Situations and problems constantly arise which serve as a basis for cooperative study. In fact, the working together of several groups and several teachers in the solution of a pertinent and interesting problem is a fine type of health teaching. Possible projects of this type include: (a) the school lunch program; (b) school housekeeping, lighting, and ventilation; (c) safety at school and in the community; (d) school recreation program; (e) health conditions in the community; and (f) control of disease in the school.

Organization of a faculty group for such cooperative teaching is a necessity and should be initiated by the principal or by the health coordinator (if one is employed). Thinking and planning together, teachers can discover needs, pool ideas, evaluate suggestions, and formulate programs. A suggested procedure for getting under way might include the following:

1. Recognition of a health problem which involves many pupils in different groups. The problem may be brought to the attention of the principal or coordinator by a teacher, a pupil, or a group of pupils and teachers
2. Calling together a committee, representative of the group (faculty and pupils or faculty alone)

3. Discussion of problem and exploration of educational needs
4. Pooling of ideas and suggestions for teaching, for committee action, for pupil action
5. Evaluation of ideas and suggestions
6. Formulation of a plan of procedure
7. Putting the plan into operation
8. Evaluation of entire effort

In some instances the need for cooperative teaching may originate not in an immediate problem but in an area of study involving several subjectmatter fields. For example, the milk supply of the community is just one problem which may be studied in agriculture, science, social studies, home economics, and hygiene. Again there is need for cooperative action so that the teaching in these fields may be related, duplication avoided, and pupil interest maintained. Teachers of these subjects on the secondary level should definitely work together in planning their courses of study for the year. It is important that each knows what the other is doing and that health material is neither monotonously duplicated nor blithely omitted. Needless to say, teachers should be sure that the sources of materials they use are authentic.

Incidental health correlations will arise in practically every subject area taught in the school. The teacher should become conscious of these opportunities and utilize them educationally. There is no necessity of injecting health material where it does not naturally fit. The opportunities are sufficient for natural treatment without "dragging it in by the heels." Most of the illustrations that follow relate to the secondary-school level where subjects are usually departmentalized. The correlated type of instruction common to elementary schools is discussed in Chapter IV.

Examples of Cooperative Health Teaching in City Schools

Reference has been made to the fact that health teaching is the concern of all teachers and that valuable contributions to health information and attitudes are inherent in several of the subjectmatter fields. Provision can be made in the school program for cooperative health teaching projects in which many or all teachers and pupils participate. Thru related area teaching and cooperative school action, health instruction can be implemented and vitalized, becoming more significant in the lives of pupils.

The following examples merely illustrate some of the teaching areas which may be used to make substantial contributions to the health program. The descriptions are necessarily too brief to indicate the complete instructional processes. Only enough detail has been given to show the possibilities which alert administrators and classroom teachers may use in developing an interest in the cooperative aspects of health instruction.

Some of the illustrations assume a departmentalized school situation such as is found in platoon schools and in secondary schools. Most of the suggestions are adaptable either to departmentalized or to integrated programs. Illustrations might have been cited for such areas as English, physics, and chemistry. The possibilities for health work in physical education and recreation are treated in Chapter VI.

Social Studies [1]

In the first example a junior high-school teacher of social studies briefly indicates the health instruction aspects of certain typical units. The basic philosophy underlying this statement is that the social studies should help the individual to understand and to adjust to his environment. Obviously, healthful living is involved in this adjustment.

> In our first unit of orientation to the new school we investigate our physical environment, studying the plan of the building, arrangement of classrooms for convenience and lighting, the purpose and use of ventilating system, and the location and care of lavatories. Quite logically we come to traffic rules in the halls, emphasizing the element of safety. In the discussion of the schedule we budget time for a week, planning all activities for balanced living of study, play, and rest. In explaining legal and illegal causes of absence we speak of avoidance of common colds by etiquette and sanitation. The subject of proper sleep comes in our drive for punctuality.
>
> We also learn about the gymnasium, its purpose and use, accenting the health side. In the same way the physical aspects of the homeroom as housekeeping, dusting, care of books, cleanliness of blackboards, adjustment of window shades and seats, general order, and cleanliness contribute to the health factor. Even more obviously we learn about the cafeteria, "what to eat and why," by planning sample well-balanced menus in keeping with the budget.
>
> Last we study the school clubs, bringing out their recreational purpose and fostering the hobby idea for mental health.
>
> We spend a great deal of time on the family as an institution, showing how the duties and responsibilities of each member bring about a well-adjusted family

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[1] Based on a statement by Sara Kroger, Oneida School, Schenectady, New York.

> life. We show how leisure time may be spent profitably within the home Usually the housing problem will occur in this unit, giving opportunity to stress ventilation, heating, lighting, plumbing, and even furnishings from the health standpoint. Last, the idea of the home as a place of rest, furnishing a sense of security and teaching morality, is certainly a health contribution
>
> An entire unit is devoted to worthy use of leisure time In this are shown the necessity for recreation, amusements of earlier times and today, community services for recreation, reading for leisure, hobbies, and games for all the family. Some time is given to commercialized amusements and the harmful effects of overindulgence in leisure-time activities.

Where the school administrator encourages the use of excursions, cooperation with various branches of the local government, scheduling of outside lay speakers, and similar procedures, it is possible for social studies instruction to deal with many important problems directly related to individual and community health:

> Another unit called "My Value to Society" can be approached entirely from the safety viewpoint. It teaches automobile and traffic regulations, fire prevention and protection, insurance, sanitation, sewage disposal, pure water supply, building codes, quarantine laws, clinics, and care of and help to the handicapped.
>
> In the eighth grade where we interpret the community, we study community agencies for maintaining health and safety regulations in home and industry We also hope to build further health protection thru the unit on propaganda where superstitions, patent medicines, and cure-alls are discussed.

The foregoing program obviously provides health instruction a logical and natural place. It is not necessary to use artificial means to build understanding and appreciation of the importance of healthful living when social studies instruction is coordinated with health instruction.

General Science

In the field of general science, many opportunities arise which are admirably suited for both the introduction and the clinching of health facts and habits. The words "opportunities arise" are indicative of teaching situations not explicitly planned for in a course of study. The individual teacher can insure the existence of such opportunities thruout the course by carefully integrating "leads" into his lesson plans. The success of related health teaching depends on the ability of the individual teacher to make the most of those opportunities which have been insured existence, in addition to those which will arise naturally from class investigations and discussions.

How does a teacher take advantage of these situations? Individual differences among teachers will, of course, color the treatments of any particular situation. The following treatment of a classroom discussion hinging on the study of the weather may suggest some useful procedures related to health teaching.

The eighth-grade class has been studying weather factors. The discussion for the day concerns "relative humidity"—its meaning and its determination. It is assumed that several attempts may be needed to get the correct pupil response which will be the only one here noted.[2]

Instructor: Shortly before this class came into the room I had the blackboards washed. You can see the last spots drying now. Where has the water gone?

Pupil: It dried up into the air. It evaporated.

Instructor: That's true That accounts for there being some water in the room. John, suppose you walk over to the window and blow your breath on it. What do you see? Water. We have thirty-five pupils here all breathing water into the air What's going to be our feeling if we keep this room airtight for the day?

Pupil: We'll all get headaches. We'll feel stuffy and sticky.

Instructor: What will happen to the amount of water in the air?

Pupil: The air will become more and more filled with water.

Instructor: That's important. It shows us that the air can hold different and ever varying amounts of water. We use the word "humidity" to describe the amount of water in the air. On warm, sticky days you've heard people say, "It isn't the heat; it's the humidity." We will attempt to prove for ourselves later the truth of that remark. I have here two thermometers. One has its mercury bulb covered with a dry wick Paul, will you read these thermometers for us?

Pupil: They both read 72° F.

Instructor: I am going to wet the wick of the one with water at 72° F. Can you notice any change taking place?

Pupil: The wet bulb thermometer is going down.

Instructor: Remember the water was the same temperature as the air in the room. Can anyone tell me why the thermometer should drop?

Pupils: (Answers unsatisfactory.)

Instructor: Let us try to solve that problem by another experiment. Mary, I'm going to place a drop of alcohol and a drop of water on the back of your hand. You tell the class how they feel.

Pupil: They feel cold. The alcohol spot feels colder than the water.

Instructor: Which one is drying faster?

Pupil: The alcohol has dried up already.

Instructor: Notice that the colder spot dried faster. Also that both were colder than the dry part of the hand. Where do we use alcohol to cool our skin?

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[2] Based upon a report by Robert Murray, Washington Irving Junior High School, Schenectady, New York

Pupil: Patients in hospitals are given alcohol baths in summer to cool them off.

Instructor: True. I'd like to show you why liquids cool off your skin when they dry. We will place some ether, which evaporates faster even than alcohol, in a watch glass which is placed on a drop of water. By fanning the glass we make the ether evaporate even faster. You can see that the watch glass has frozen to the water it was resting on. The evaporating ether took enough heat from the water to lower its temperature below the freezing point. Liquids absorb heat when they evaporate. Someone tell us where else he has noticed this.

Pupil: When we are standing around all wet after swimming we are cold, but when we dry we are warm again.

Instructor: Good. Do you see now why it is a good idea to have a towel along to dry quickly? Those wet feet and clothes which we are apt to disregard in the winter and spring make us colder than usual as they dry off A quick change saves us a bad cold or even worse. I am reminded of how you boys like to throw the windows open to cool off after coming in all perspiration from the gym class. Does anyone see the danger in that?

Pupil: We can catch cold by drying off too quickly in the cool air.

Instructor: Yes. That quick-drying perspiration is likely to cause dangerous chills. Keep this idea of coolness from drying perspiration in mind. I am going to come back to that later. You can see now why the wet bulb thermometer is lower. James, suppose you check the readings now and at the same time state an explanation.

Pupil: The dry bulb reads 72°; the wet bulb, 62°. The water evaporating from the wet bulb took heat away from the mercury, making it contract.

Instructor: Remember that ether evaporated faster and thus took away more heat. What would happen if the water were made to evaporate faster?

Pupil: The difference between the two bulb readings would increase.

Instructor: And if the water were made to evaporate more slowly?

Pupil: The difference between the two becomes less.

Instructor: Can anyone offer a suggestion as to what would vary the speed with which the water is evaporated?

Pupil: A dry day would evaporate the water faster. A wet day would mean slower evaporation.

Instructor: Now we can see why this device enables us to determine the amount of water in the air. On a dry day the difference between the thermometers is greater than on a damp day. By the use of these wet and dry bulb thermometers and this humidity chart we can calculate what we call the "relative humidity" of the room. You can see on the chart that the greater the difference between readings, the smaller the numbers become which indicate the percent of the air filled with water vapor. Today's humidity in the room is 49 percent. This is a healthful figure Any humidity reading between 40 to 60 percent is ordinarily acceptable for good health. Under what conditions would you expect a high humidity?

Pupil: On hot summer days just before a storm.

Instructor: Yes. When would you find a high humidity inside?

Pupil: When there are a great many people in the room, the air gets sticky and stuffy. Is that from water in the air?

Instructor: That's right. Remember I told you that we would get back to the point previously mentioned, that liquids (in this case, perspiration) take away heat as they evaporate. Your perspiration which is continually evaporating from your body controls your body temperature thru its cooling action. When a room gets saturated or filled with water vapor it is like a sponge; it can hold no more. That means that your perspiration stays on your skin. That accounts for the wet, sticky feeling. The hot, stifling feeling is due to the failure to have heat removed by perspiration evaporating. What is the solution to the problem?

Pupil: Circulate fresh, dry air so that more moisture can be evaporated.

Instructor: Good You will recall, perhaps, air conditioning advertising. Air conditioning not only regulates temperature but also keeps the humidity between 40 to 60 percent.

Pupil: What do they do to keep it there?

Instructor: By circulating fresh air which is of high or low humidity as the occasion demands. In the winter, air in homes needs to be watched carefully. Which direction does the humidity tend to go? Up or down?

Pupil: We have to add water to our furnace so it must be that the air is dry.

Instructor: Right. Heating devices lower the humidity. Perhaps you have noticed your mouth drying up, causing you to take frequent drinks of water. Dry air irritates the lining of your nose and mouth. That dryness contributes toward the chance of catching cold. Make sure that the water reservoir in your furnace at home stays filled.

We have on the blackboard a few problems related to the work we have just completed. They are problems which will require some original thinking on your part.

1. Some days in summer we are more uncomfortable than on others which have a higher temperature. Explain.
2. How does a fan cool us even tho it is blowing the same air that is making us warm?
3. Why are wet swimming suits cold even tho the water they come from is the same temperature as the air?
4. Why does spraying water on hot days momentarily cool off the ground?
5. Why does the humidity in a classroom rise as the morning class begins?

Even a casual survey of courses and texts in general science indicates a fairly uniform subjectmatter content despite a great variance in treatment. The following topics, for example, offer opportunities for both indirect and direct health teachings: air, combustion, heat, water, distillation, light, sound, bacteria, and foods. Where teacher and supervisor are alert to the purposes of the health program, general science can be an effective channel for influencing both individual and group health behavior.

Home Economics[3]

In a program where there is planning for integration of subjects, many areas of health education and home economics education will dovetail so completely that the integration will be largely a matter of working out the procedures. Administrators should encourage teacher and pupil participation in the planning of any program and recognize the necessity of basing such a program on the needs of the specific community and particular groups and individuals in that community. In many of the areas of home economics education the correlation with health education is obvious. The following is not offered as a complete discussion of the possibilities of correlation; it is intended to be suggestive rather than limiting.

There is general agreement that the right food habits are closely associated with good health and yet we know that it does not follow that acceptance of the truth insures its practice. There are still fertile fields for home economists to cultivate to improve the food habits of people of all income levels thruout the United States. This is not a new challenge. It was recognized and accepted in the early days of so-called "domestic science" The fruits of those early efforts are evident today, but there is still much to be desired in the food habits of the nation.

Teachers of foods and nutrition are attacking the problem in many ways to meet the needs of their pupils in such a manner that knowledge gained in home economics classes is truly functional Adequate dietaries are planned and prepared in foods classes to meet the needs of families at different income levels. Pupils develop a background of nutritional facts which help them to evaluate the wide variety of available food items on the market today. Children of foreign-born parents are encouraged to study and evaluate the dietary habits of the country of their parents' birth. A realization that it is natural for adults to cling to the customs of the home of their youth and an understanding of those customs will frequently improve parent-child relationships. Of equal importance will be the realization by the pupil that with a few additions to, or substitutions in, the family dietary it can be made adequate according to the nutritional standards she has learned.

Home economics teachers in schools certified for using surplus commodities are supervising the preparation and serving of a hot lunch at school. In this way the problem of faulty nutrition can be solved by adding the lacking nutrients to the pupils' diets. The hot lunch at school should also be regarded as a means of improving eating habits. A study of the working ability and mental alertness of pupils could be carried on cooperatively by pupils and teachers in controlled situations to test the results of a cold lunch eaten hurriedly in contrast to a hot lunch eaten more slowly in pleasant surroundings.

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[3] Based upon a statement by Lucille Starr and Marjorie Ott, Mt Pleasant High School, Schenectady, New York.

Realizing that girls and boys of high-school age may be called upon to care for members of the family who are ill, the school physician, nurse, and home economics teacher may plan, with the cooperation of the pupils, a unit on caring for the sick in the home. The cooperation of outside agencies such as the American National Red Cross and the Public Health Nursing Association can be invited for demonstrations of nursing technics, and in addition the pupils should be allowed as much participation and practice of these technics as is possible with available equipment. The home economics teacher can contribute her share in such a cooperative program by directing the study of the invalid dietary.

The correlation between home economics education and health education is readily seen in a study of housing. House care and sanitation have been taught since the beginning of home economics. These skills and technics for making a home livable are given a broader interpretation today but are none the less important. In the study of housing, there is increased recognition of the factors contributing to a safe, sanitary, and attractive home. Boys and girls of high-school age have a growing interest in homes—their present home, but more particularly in a home of their own in the not too distant future. They are developing standards for living and consumer purchasing. These standards will affect the housing and human welfare of the community of the future.

The informality and easy rapport characteristic of many home economics classes in secondary schools provide opportunity for the adjustment of social problems of young people. In some classes the members may be told that the course is theirs to plan in order that it may help them to meet the problems which confront them now or are apt to confront them in the rather near future.

> Thru the use of question boxes in which anonymous questions may be placed, all sorts of conflicts come to light. Youth has a difficult time assuming an adult role, due largely to the attitudes of their elders. One day they are treated as immature children; the next, reprimanded for their childish behavior. There is no status for the adolescent. He is neither adult nor child—one day one, one day the other, his cues coming largely from older people.
>
> During the depression, every effort was made to keep youth in school They were not to want jobs. Now that they are needed for defense, they are adults.

So there is a definite conflict on this score of their status. Boys and girls encounter all manner of trouble at home. Some parents seem unable to cope with these young people who are trying desperately to assume an adult role Thus problems arise within the home and there results conflict between parent and child.

Thru discussion in class of problems presented anonymously or as "my friend's problem," many a boy and girl have been helped with their conflicts

The mental state of a high-school student is shifting; it fluctuates from the feeling of being quite important to an inferiority complex. These fluctuations are accompanied by their characteristic behavior patterns. Emotional instability with the social insecurity about which the present generation knows much needs a clearing-house such as is found in classes in home economics where social problems, personal problems, and economic problems are laid open, discussed, and evaluated.

In connection with the work planned, outlined, explored, and evaluated by students under teacher guidance in home economics courses, all sorts of vistas are opened up These vary with the needs, capacities, and backgrounds of the group and of individuals in the group. Problems of living successfully and satisfyingly in the family and in the community open up many avenues of expression and offer opportunities to understand people which always work to the advantage of the individual who is doing the work. In one school it was found that girls working with problems of child care, training, and development unconsciously did a perfectly splendid job of recognizing personal problems and habits which they had never before recognized or admitted. Violent temper tantrums in children became quite personal and several girls went to work on themselves.

One girl who disliked children cast the only dissenting vote against work with children but agreed to follow along only because the group voted to do so Too many babies in her own family and conditions in the home were responsible for her attitude. After doing her share of first observing, then participating, in the nursery school and studying child behavior, her attitude gradually changed and, incidentally, her whole attitude toward her home and herself.

When problems of defense are mounting rapidly, many girls are needing help in stabilizing emotions. The marriage age is lowering and hurried marriages are the order of the day. There is need to differentiate between love and conscription. The changing roles of women make a special demand for mental and emotional health. It seems important that every school should develop its own program of health education and integrate subjects so well that boys and girls may have opportunities to find answers for their every need. Sex education, temperance, and other problems related to home life are discussed in Chapter IV.

Biology [4]

Biology properly interpreted and taught becomes a rich source of understandings, information, and attitudes concerning health. The concept that all forms of life have a few common basic needs which must be met if life is sustained is fundamental in biology. This is particularly emphasized in a study of the animal world when needs of humans are under consideration. The basic processes of digestion, assimilation, respiration, excretion, sensory stimulation, and muscular response are important in the maintenance of all animal existence, and boys and girls may gain important knowledge and understanding of such processes thru their study of animal life.

The adaptations of organisms to their environment is another phase of biology which holds important implications for health. The necessity of such environmental needs and adaptations thruout the entire plant and animal world is evident when one becomes acquainted with the world around him. Biological faults in man's modern city environment may be considered as an outgrowth of this problem. Lack of sunshine, fresh air, space for muscular activity, and natural foods are biological handicaps in the civilized world. Means of adjusting to such factors constitute an interesting study. Man's increasing control of his environment needs to be evaluated as it relates to human biological welfare.

The relation of man to microscopic organisms is another important aspect of biology. In such a consideration the disease-producing organisms receive attention and boys and girls can study the nature, spread, and means of control of important communicable diseases. Actual experience with microorganisms by means of the use of microscopes and bacteriological experiments is invaluable in the development of understandings of microscopic life.

From knowledge gained by careful scientific research and experimentation, man has made tremendous advances in recent years in the control and prevention of many diseases. He has learned that the causes of disease are many. If man is to succeed on this earth, he must learn how to combat the organisms and conditions that are inimical to his welfare. In order successfully to combat an organism, its life history and habits must be clearly understood. In biology students should acquire these important health learnings. A knowledge of the causes of diseases and their prevention will fall quite naturally into a biology course. Antiseptics, asepsis, quarantine, immunization, sanitation, health supervision, and control of contagious diseases are suggestive of important topics.

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[4] Based upon a report by Esther Fagel, Mt Pleasant High School, Schenectady, New York.

In order to know how best to care for the body, we need to know how it functions. The human body is similar to that of lower animals and very much like that of other mammals. Therefore, rats, cats, and rabbits are used in the laboratory to study anatomy and physiology.

All organisms need food for growth and energy, but most foods cannot be used by the body unless they are digested. Health also depends upon the proper choice and preparation of food. The necessity for vitamins in preventing certain diseases may be proved by experiments with rats or guinea pigs in the laboratory.

Biology also includes a study of man's nervous and endocrine systems and their interdependence. How one develops mentally and physically is determined not only by his heredity and diet but also by the secretions from his ductless glands. These glands which secrete chemicals called "hormones" have a tremendous influence on one's mental and physical development. He may be extremely thin or stout, not because of what he eats but because his thyroid gland is not functioning normally.

These and other aspects of biology may be explored in greater or lesser degree to the advantage of students. Where there is no special course in health in the high-school curriculum, the emphasis placed upon such teaching in biology classes should be increased. At all times efforts should be made to coordinate such teaching with other phases of the school health instruction program.

An Illustration of Integrated Health Instruction in a Rural School [5]

A group of rural children in Grades VI, VII, and VIII undertook to answer the problem of "how to improve the lighting in our classroom." These students had previously experienced little of the problem-solving technic of instruction. They had been accustomed to studying hygiene from a textbook in the traditional recitation manner.

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[5] Utah State Board of Health. *Health Bulletin No 2.* (James A Ball, Loa School, Wayne County, Utah)

The teacher and pupils became interested in their problem thru a light meter which was lent to them. This served to disclose the inadequacies of their classroom and to motivate them to want to do something about the problem. A group decided they would like to learn what constituted good lighting and so began reading and discussing what they could find on the subject in the books and pamphlets loaned from the state board of health library. Thru the teacher's guidance, they began to criticize and question certain lighting conditions at home, in the church, and at school. Definite plans were then worked out by the group for making the study. Thruout the study reports were made and written records kept. They evaluated conditions in their own room, in terms of facts, and studied and compared their situation in detail to the standards suggested in *A Program of Eye Health in a School System,* a publication of the National Society for the Prevention of Blindness.[6]

Members of the group started to work measuring the glass area in relation to floor area of the classroom. They found that the glass area did not meet the minimum standard. The placement of windows was seen not to be satisfactory because there were windows on two sides, making cross lighting, and the mullions between windows were found to obstruct the light.

The students used the light meter to test the intensity of lights about which they were doubtful. In some parts of the classroom, especially away from the windows, there was very little light. In the front of the room there was a glare on the blackboards because of the light coming in from two of the side windows. The meter showed that in parts of the room there were less than two foot-candles of light, and in other parts, nine to twenty-five foot-candles. At different times of the day they noticed a variation of light in the same place.

The blackboard on the side of the room which was not used much seemed to darken that part of the room where the sixth grade sat. They decided that this blackboard could probably be covered with wrapping paper which would reflect more light. Their seats were so arranged that no one faced light, but there was much glare on the front blackboard. They thought the charts and maps were well lighted but not particularly well located for class use. In considering the question of light reflections, they found the walls and ceiling were a cream color but were quite dirty. According to tables of reflection, 75 to 85 percent of light should come from light colors, but much of the reflection value of their walls must be lost because of the dirt.

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[6] Smith, Mary E *A Program of Eye Health in a School System* New York National Society for the Prevention of Blindness, 1934 14 p

After summarizing their findings, the children decided that there were many things they could do to improve their situation. They decided the following things needed to be done:

1. Change the direction of light for some of the pupils, especially those exposed to glare and cross lighting
2. Protect all children from glare and leakage of light
3. Try to get more light in certain parts of the room, especially the side where the unused blackboard was located.
4. Change the arrangement of school furniture and some of the equipment, like maps and charts, for greater ease in seeing.

The students were rather at a loss as to how to begin since this type of activity was so new to them. The questions raised by the children were listed as a possible way of discovering the next steps:

1. Does the blackboard on the side have any effect on the amount of light?
2. Would the chart on the wall near the desk have any effect on the amount of light?
3. What are the effects of poor lighting?
4. Why do we say that the eye is like a camera? (This was demonstrated.)
5. How can we get more light in our room?
6. What are the advantages of good vision?
7. Why do we wear glasses?
8. If we appealed to the schoolboard, could it change the windows?
9. What does good lighting do for one?
10. How does the eye use light?
11. How much light should one have?
12. How does lighting today compare with lighting long ago?
13. How should we care for the eyes?
14. What are the common defects of the eyes?
15. Should everyone go to an eye doctor even tho his eyes do not seem to trouble him?
16. Of what value will this study of lighting be to us?
17. What are the causes of eye infection?

This rather heterogeneous array of questions provided tangible materials for further study. The different grades furnished reports and information on the various problems. When they had completed their work, there were certain conclusions which they drew:

1. Colors have an effect on lighting.
2. The blackboard on the side of the room naturally darkened that part of the room.
3. Poor lighting not only produces bad effects on the eyes but on the whole body, and thereby impairs efficiency of work.
4. Eyes are very delicate structures and are so important that we should take good care of them.
5. Too bright or strong light is as harmful as too little light.

The results of the project were summarized as follows:

1. The schoolboard became interested in improving lighting conditions in the school.
2 The parents became interested and cooperated in helping as never before, some changing the globes and lighting in their own homes.
3. The children worked splendidly together and developed good social habits of cooperation.
4. They developed a stronger feeling of loyalty to their school. More and more, they felt that the school was their home and that they had some responsibility in making it congenial and attractive.
5. The children became eye-conscious in school If they felt the light was not good for studying at their seats, they would quietly adjust themselves to improve the condition.
6 And lastly, the children have learned more about eyes, vision, and sight than they would have learned if they had confined themselves to the textbook and only a few reference books. The work and experience, along with the study in the wide range of references, were very interesting and made the children say, "Let's do more work like this"

Administrative Procedures

The statement has been made in this chapter that upon the school administrator falls the task of making the school health program effective. This statement is particularly true with respect to health emphases which may be made in those school subjects where the primary goals are not health education.

Why is this so? In the first place, in the various areas of the curriculum teachers have been prepared to concentrate their efforts upon the subjectmatter of their respective areas The teacher of biology tends to focus upon "pickled grasshoppers" and the customary facts in the field of his specialty. Teachers of the social studies have a similar focus upon the clearly recognized aspects of their own subjects. Other teachers, even tho they are in general programs, such as the typical city elementary school or the rural school, also tend to be too respectful of the boundaries of the various areas of human experience. Altho for decades educators have discussed "correlation" and, in more recent years, "integration," there is likelihood that the health aspects will be neglected unless something systematic is done to guide classroom activities.

It must be clearly recognized that classroom teachers are not always at fault in this matter. Teachers have to adapt themselves to administrative policies, bell-ringing schedules, courses of study, standardized tests, and a host of other factors over which they have little control. Too frequently administrators have set goals for instructional programs and then, usually inadvertently, set up unnecessary impediments for teachers. A few specific aspects of the problem will be reviewed:

Administrative policy—In some instances the policy of the board of education and superintendent with respect to health education is not clearly defined. The health agencies within the school system may, under this policy of drift, do effective work, but the school program as a whole makes only incidental contributions to the health program. From observation it has been noted that health education permeates the entire instructional program when healthful living, not subjectmatter, is clearly recognized as one of the major goals of the educational program

Organization—Departmentalized subjectmatter plans, whether at the elementary- or secondary-school levels, do not encourage cooperative efforts in health education. In fact, no administrative plan or device works automatically to promote instruction. It is necessary constantly to examine the effect upon classroom activities of such commonplace things as fire drills, schedules, testing programs, promotion standards, marking systems, and classroom equipment. Upon the school administrator, particularly the principal, falls the responsibility of making administrative procedure an aid and not a hindrance to instruction.

Supervision—In recent years, instructional leadership has assumed increased importance as a function of school administrators. This fact is of importance to health education Working with the committees of classroom teachers it is possible to prepare courses of study in which the health contributions of all subject areas will be developed. To provide teachers with bone-dry outlines of subject-matter-to-be-learned and then to expect an effective, integrated approach to healthful living is, to put it mildly, wishful thinking. Teachers also need to work in groups studying methods and materials dealing with health education if, in many instances, they are to overcome the deficiencies of their preparation.

Health education in the various related areas of the curriculum in many school systems is frequently not carefully planned. Here and there, where the students themselves have expressed their interests and needs to an alert teacher, exceptionally creative health experiences have been developed. If this casual basis is to be replaced by a systematic health program, then teachers must have opportunities to plan and to work together. If these opportunities are made available, it will be because the school administrator feels that the problem deserves appropriate consideration and action.

CHAPTER VI

Health Aspects of Physical Education and Recreation

WHILE HEALTH EDUCATION is interwoven into all parts and departments of the school program, there are particular relationships with physical education and recreation which make it essential that these be closely coordinated with the school health program. There is need for protecting pupils from excessive and inappropriate activities in physical education and there are specific contributions which physical education makes to health. Recreation plays an important role in the development and maintenance of emotional health and also is a wholesome antidote to monotonous, tense, and highly emotional work in which presentday commercial and industrial organization places many people. This chapter will consider some phases of physical education and recreation and the relationship of these areas of education to the school health program.

Health and Leisure-Time Values

Perhaps the outstanding development in physical education during the past few decades has been a broadening philosophy which now centers attention on the effect of physical activities on the entire personalities of pupils rather than solely their effect on muscle, circulation, respiration, and other bodily functions. Whereas programs of so-called "physical training," prevalent in the early 1900's, limited their objectives to the development of strength, neuromuscular coordination, posture, and physical endurance, presentday programs add to these attention to recreative interests and skills and to the social values resulting from pupils' learning to play with each other, to give and take, to choose and respect leaders, and obedience to rules of the game. Basic to this changed philosophy are the concepts that physical education is a phase of education rather than merely an exercise period and that physical education contributes to many of the objectives of education. The content of physical education in schools reflects this change in philosophy and gives a prominent place to games, dances, and athletics.

Physical education contributes to health, strength, and physical fitness; to social education; and to the development of enduring interests and skills. Its objectives may be listed as follows:

1 To provide activity during the school day as a preventive of fatigue; a means of self-expression; a method of relaxation from more formal types of education; an aid to the development of strength, physical fitness, and organic power, and a contribution to health, particularly mental health.

2. To utilize school and after-school activities as opportunities for pupils to learn how to react to other pupils and to leaders, thus contributing to their social development and helping them to grow in social adaptability.

3. To teach the skills of many types of activities and provide sufficient opportunity to use these skills so that a reasonable degree of proficiency, which will encourage participation outside school and in the years following the completion of school, can be attained

The attainment of these objectives requires a physical education program, for both boys and girls, which includes (a) a class program, and (b) a program of intramural athletics and sports days. In all but small communities these will be augmented by an interscholastic athletic program for senior high-school boys. In the ideal program these various phases of physical education will be closely coordinated, with personnel and facilities intelligently and judiciously allotted to each.

Physical Education Class Program in Elementary Schools

Presentday schools universally provide regularly scheduled classes of physical education in which the basic skills of various games, sports, and rhythmic activities are demonstrated, taught, and practiced. The class program in physical education is required of all pupils; frequently state law makes it mandatory.

In the elementary grades, physical education is usually taught by classroom teachers with the help, wherever possible, of specially prepared supervisors. Whether or not the help of a supervisor is available, teachers should have the assistance of a locally prepared course of study giving suggestions for units of instruction, helpful hints on methods, suitable references, recommended plans for evaluation, and suggestions for integrating physical education with other phases of their program. Such a course of study for physical education should be prepared thru the cooperative efforts of administrators, supervisors, teachers, pupils, and others in the same manner as materials for other parts of the school program are prepared.

In order that physical education may be conducted out-of-doors, except when the weather is inclement, a minimum play area of three acres adjoining each elementary school is desirable.[1] When indoor classes are necessary, they may be conducted satisfactorily in the classroom for kindergarten and first grade, but for other grades a playroom is desirable. The playroom need not be equipped as a gymnasium but should provide unobstructed space not less than the size of a regular classroom, preferably the size of two classrooms, where running games may be played safely without danger of tripping or running into desks and chairs. Windows and doors should be screened for protection of property and pupils. Adequate indoor and outdoor space is essential for the proper development of a modern physical education program.

In addition to space, it is essential that various physical education supplies be made available. Such things as balls, bats, rackets, jumping ropes, victrola records, music, jumping standards, nets, baseball bases, table tennis equipment, and mats are as essential to the physical education program as books, maps, and charts to other parts of the school program. Superintendents and principals should see that adequate budgetary provisions are made for these supplies.

Time allotment for physical education varies, but it is believed that a minimum of thirty minutes daily—fifteen minutes or more in the morning and a like period in the afternoon for lower grades and a single period for upper grades—can profitably be used in elementary schools for class instruction in sports, games, dances, and other forms of physical education. This time allotment would be in addition to that given for recess periods where such periods are used.

Administrative Phases of the Secondary-School Class Program

Physical education at the secondary-school level is departmentalized and should be taught only by those specially prepared and certified in this field of education. Adequate space for physical educa-

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[1] National Recreation Association *The New Play Areas; Their Design and Equipment.* New York. A. S. Barnes and Co., 1938 242 p

ACCIDENT PREVENTION—*The school helps to develop the attitudes and skills necessary to live safely in the modern world. The physical education program builds coordination and alertness which in turn contribute both to sound limbs and to longevity. Pupils are taught to be watchful of the safety of others as well as of their own welfare.*

Photograph by
Rochester (New York) Public Schools

tion is particularly important at the secondary-school level. It is at this level that interest in team games is intensified and that the skills of many individual sports should be taught. The crowding of large groups of pupils into a small gymnasium or on a limited play area makes impossible a constructive modern program of physical education. For outdoor activities, from ten to twenty acres of play area should be provided for secondary schools. For indoor programs, adequate gymnasiums in the ratio of approximately one for each 1000 pupils should be provided.[2]

A written course of study for physical education, locally prepared, is important for secondary schools. It should give specific and progressively more difficult pupil goals adapted to their capacities. Pupils' progress in physical education should be evaluated by methods similar to those used in measuring their progress in other phases of the educational program (see tests listed in Appendix).

The need for proper supplies and equipment for physical education is as great at the secondary level as at the elementary level, perhaps even greater. There should be sufficient supplies to permit all members of the class to participate at one time. Inadequate supplies may cause one part of the class to waste most of its physical education period while another part uses the limited amount of available equipment. Such poor administration can be avoided thru proper budget provisions for physical education supplies. Supplies provided for class-time physical education will also be used, quite naturally, in after-school programs of sports and recreation.

The scheduling of pupils for physical education is an important administrative task greatly influencing the value of secondary-school programs. In some schools, pupils' schedules are prepared so that the two subjects which all pupils take, physical education and English, are scheduled first. This plan permits pupils to be scheduled according to interests, needs, height-weight-age, strength, or previous accomplishments in physical education. While various bases for scheduling classes all have their warm advocates, it is believed that each is better than the hodgepodge which results from the promiscuous scheduling of pupils whenever they have a free period, regardless of interests, abilities, or needs. The scheduling should give particular attention to handicapped pupils so they may participate in the types of activities which their handicaps permit. The so-called "physical moron," whose neuromuscular skills and strength are considerably below average, should also be given special consideration in scheduling. To place him with a group vastly superior to himself may cause discouragement, humiliation, and embarrassment, with detrimental personality effects and a lifelong influence on his attitudes toward physical activity. The secondary-school principal who arranges for the intelligent scheduling of physical education classes is laying a foundation on which a modern physical education program can be built.

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[2] Williams, Jesse F , and Brownell, Clifford L *The Administration of Health and Physical Education.* Philadelphia, W. B Saunders Co , 1939 634 p.

A number of secondary schools now provide five periods a week —one each day—for physical education. This plan is recommended wherever facilities permit. Some schools provide only two or three periods a week, usually because of inadequate staff or facilities. It is suggested that these schools plan for increased staff and facilities so as to permit the time allotment suggested. Because of what physical education can contribute to presentday youth, this allotment is desirable even tho it means decreased time to other areas of education. From a practical point of view, secondary-school principals may find that the allotment of a period for physical education each day simplifies the scheduling of pupils.

In recent years attention has been directed to the possibilities for coeducational physical education, including various sports such as golf, swimming, and winter sports, as well as social dancing. This desirable trend is one that might be accelerated profitably. Thru coeducational activities at school, boys and girls are prepared for normal reactions to the many out-of-school situations where they have opportunities for joint participation in sports. Also, such programs offer opportunities for wholesome boy-girl relationships under desirable conditions.

Increased Attention to Intramural Sports and Athletics

Intramural sports and athletics constitute an extremely important part of physical education. It is this part of the program which gives pupils an opportunity to put into use the skills learned in the class program. It is a program for all pupils, regardless of size or proficiency. Among activities included in intramural programs are badminton, archery, soccer, basketball, volleyball, golf, swimming, hockey, bowling, hiking, riflery, winter sports, dancing, touch-football, and other sports and games. Particular emphasis is now being given to those activities which pupils may use in later life.

The organization and conduct of intramural programs present several administrative problems. One has to do with personnel. How can personnel be provided for such an extensive, varied program? Altho it is part of the physical education program, it frequently cannot be carried on without the help of interested teachers of other departments. During a season in which he has responsibilities for coaching an interscholastic team, the physical education teacher has little time to devote to intramural programs. To ask him to do both usually results in neither job being done well. Assigning faculty members from other departments in the school brings up the question of how much after-school activity may be expected of a teacher without providing extra compensation. This cannot be answered in one way for those working in the physical education field and in another for those in other departments. Each school must develop some plan for providing personnel for after-school activities. If the time required for after-school athletics is greater than that usually required of other teachers, appropriate adjustments must be made. Frequently, a reduction in school-time assignments will be found to be the preferable arrangement.

In addition to securing sufficient personnel to give leadership to intramural athletics, the school administrative head must see that there is some definitely arranged schedule for the use of gymnasiums and play fields by different groups. Neither boys nor girls should be allowed to monopolize physical education facilities, nor should those on interscholastic squads be permitted sole use of available space. A specific time schedule, allotting certain time to boys and other time to girls and specific time for both interscholastic and intramural activities, is essential for the smooth functioning of a complete physical education program and is the only way that assures an adequate use of facilities by girls and intramural groups. The preparation of such a time schedule is the responsibility of the secondary-school principal or some person to whom he delegates this responsibility.

For high-school girls, "sports days" have proved a valuable type of recreative competition. They follow extensive intramural programs, offer opportunities for the less skilful, and emphasize social as well as physical values. Sports days, as well as other high-school physical education activities for girls, should be under the leadership of women teachers, and officiating at all girls' contests should be by women officials. In all physical education for girls, and particularly in competitive contests, special rules suited to the capacities of girls are recommended.[3]

Sports clubs, such as hiking clubs, swimming clubs, bowling clubs, and tennis clubs, are effective forms of intramural activities for either boys or girls or as coeducational clubs. While centered around a particular form of activity, they, like all other club programs, offer opportunities for social education and practice in the democratic procedures used in clubs.

Interscholastic Athletics and Boys' Physical Education Program

The interscholastic program for boys at the senior high-school level gives the most skilled players of the school opportunity to match their skill with groups equally superior. It is an integral part of the physical education program and contributes directly to educational objectives. In addition to its value to individual participants, interschool competition can be an aid to developing desirable school morale. As with other parts of physical education, best results are obtained when adequate facilities are available and when, in selecting personnel, character and personality as well as education and athletic proficiency are considered.

While interscholastic athletics are an integral part of physical education programs for boys at the senior high-school level, they should not be permitted to usurp an undue part of physical education teachers' time or a disproportionate use of gymnasium, playground, or swimming pool facilities. A well-balanced program of physical education will first provide an extensive, varied program of intramural sports, and then, if necessary, the intramural program will be supplemented with an interscholastic program. A program for large groups certainly must be given precedence over a program for a few.

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[3] American Association for Health, Physical Education, and Recreation *Standards in Athletics for Girls and Women* Washington, D C. the Association, a department of the National Education Association, 1937. 56 p

Because interscholastic athletics are a part of the school program of education, the effectiveness of the coach is measured not solely by the number of games his teams win but by his contributions to social and character education. Unquestionably the physical educator working in the interscholastic realm is in a strategic position not only to give guidance to those under his immediate supervision but to influence the attitudes, ideals, and behavior of the entire student body.

Interscholastic athletics should be amateur competition in fact and in spirit. Pupils should consider participation as recreation and should play for the joy of the game rather than because the school, principal, or coach desires a winning team, or because of any anticipated material reward. In presentday administration, school officials responsible for administering interscholastic sports consider the effect of these activities on the pupil as a whole and find it important that pupils develop interests in a variety of activities so as to prevent undue absorption in one.

Interscholastic athletics are not recommended for elementary and junior high-school boys. At these levels most boys are prepubescent, growing rapidly, and insufficiently developed to withstand the physical and emotional strain of interscholastic competition. Their needs can be met best by a varied program of intramural activities. In a similar way it is recommended that girls' programs be limited to intramural, sports day, and club programs.

As part of the school physical education program, interscholastic athletics should be directly administered by school authorities. There is no place for alumni control or control by outside agencies or by students. Students may act in an advisory capacity, but actual control must be retained by school administrators. A type of outside control of school physical education programs is that in which school groups are invited to participate in athletic contests and tournaments conducted by nonschool groups. These may unduly emphasize one phase of physical education and by their disrupting influence hinder the school in the conduct of its own planned, constructive program.

The educational outcomes of the interscholastic program depend to a great extent on the preparation, character, and ideals of the teacher in charge. He should be a bona fide member of the school faculty and paid entirely from board of education funds. He should be technically trained and fitted by disposition and ability for work with boys. It is particularly important that he fully appreciate the educational opportunities which his close contact with pupils makes available.

The financing of interscholastic athletics from gate receipts and athletic association memberships creates many problems. Sometimes receipts are insufficient to provide adequate equipment for the proper protection of players. At other times receipts will be more than is necessary for financing the interscholastic program, and surplus funds will be used for other purposes. This may result in requests for athletics to finance other activities, with a resultant effort to have the athletic program make as much money as possible. The natural result is the commercialization of athletics with emphasis on gate receipts rather than on educational outcomes. Occasionally such emphasis results in pupils playing when not in condition to do so and in such an extreme emphasis on winning that principles of sportsmanship are sacrificed on the altar of victory.

As one way of avoiding the dangers of commercialism, it has been suggested that the interscholastic athletic program be financed from tax funds. This stand is taken on the ground that interscholastic athletics are an integral part of education and should be financed as are other phases of education. There is need for further study of this suggestion. Altho it is undoubtedly true that such a plan would solve many of the problems associated with interscholastic athletics, it is also true that available tax funds should be used first for a diversified, after-school, recreation program for all pupils.

Physical and Mental Health thru Physical Education

Physical activity stimulates the circulation of blood, increases the appetite, and improves the functional capacity of muscles including the heart. Thru activity, physical endurance may be developed and neuromuscular skills learned. From the health point of view, the physiological effects of exercise are an increase in functional efficiency and organic power. In other words, the body becomes more efficient in performing physical activity and withstanding strain and exertion. Thru this development of organic vigor and functional efficiency, exercise contributes to physical health.

Physical education also contributes to mental health thru the personal satisfaction, joy, and pleasure which accompany participation in various activities. When an individual participates in play, his body, mind, and emotions are working together; he is functioning as an integrated personality; and it is this integration of functioning which is the foundation for mental health.

While recognizing the mental hygiene value of recreation and the value of exercise in developing strength, neuromuscular skills, and organic vigor, we must not lose sight of the fact that, as far as is known, physical strength produces no immunity to disease. A strong, robust body may be an asset in recuperating from sickness, but well-nourished, well-developed, muscular individuals are as likely to have colds, rheumatic heart disease, tuberculosis, diphtheria, appendicitis, and certain other afflictions as are the weak and underdeveloped. It is essential that children develop physical strength, endurance, and skill, and it is just as important that they receive all known treatment for the prevention of disease. Consequently, in addition to programs of physical education it is essential that schools develop well-rounded, integrated programs of health protection, health guidance, and health instruction. A physical education program cannot take the place of a health program, nor can health education take the place of physical education.

Teachers of physical education have many opportunities for incidental health instruction. In particular, opportunities for discussion of cleanliness, appropriate clothing, and the need for individual drinking cups occur not only in the class program but in connection with intramural and interscholastic athletics. Providing individual cups and individual towels for members of a football or basketball team during regularly scheduled games with other schools is a more effective way of teaching the dangers of infection from common articles than lecturing on these subjects in a class.

Pupils participating in athletics frequently ask physical education teachers about diet, rest, care of minor injuries, and acceptable first-aid procedures. These reflect pupils' interest in health as a basic requirement for maximum performance in physical activities. All such questions should be answered carefully, completely, and accurately.

Safeguarding Health in Physical Education

There are many necessary measures for safeguarding the health of pupils participating in physical education activities. Some are the responsibility of the school medical adviser, others the responsibility of the physical educator, and still others are administrative in nature.

Pupils participating in strenuous athletics, whether in a class program or in interscholastic or intramural activities, should have the protection afforded by an annual medical examination. As outlined in Chapter III, "Guidance of Individual Pupil Health," this examination is best obtained from the pupil's private physician, but where this cannot be arranged, examinations should be conducted periodically by the school medical adviser. At the high-school level it is desirable that a tuberculin test be included and positive reactors be X-rayed.

On the basis of information received from pupils' private physicians, from their health history, and from his own examination, the school medical adviser should, either directly or thru the school nurse, inform teachers of the intensity of physical education, that is, mild, moderate, or strenuous, in which each pupil may participate. For pupils with defects or abnormalities, special adjustments should be made so that the program will be in keeping with their limitations. These adjustments must give due consideration to the emotional reaction of pupils to programs which are different from the rest of the class. They must be taught to accept the limitations imposed by their handicaps, while at the same time recognizing the extent to which they may enjoy certain types of games and activities. Sympathy and kindliness are required, but pampering and oversolicitous attention may have detrimental effects. With an adequate staff of well-prepared physical educators, desirable facilities, and close coordination of the work of school medical advisers and physical educators, it is possible for schools to provide a suitable physical education program for all pupils.

The physical education teacher should be conscious of his responsibilities for the health guidance and health supervision of all pupils in his charge. He must be sure that his pupils, whether in a class program, intramural program, or interscholastic program, have no defects which might be aggravated by strenuous activity. He must observe them day by day and recommend medical examination or care when unusual conditions are noted, such as extreme fatigue, breathlessness, or pallor. He should be well prepared in first aid and should utilize the many opportunities which arise to present information on this subject to his pupils.

Close cooperation between school medical advisers and physical educators is needed in developing plans for excusing from physical education those who are temporarily physically below par. Those convalescing from serious sickness or operations and pupils who are just recovering from colds should be excused from vigorous physical activity. With attractive facilities, a program adapted to pupils' interests and abilities, and a teacher with a pleasing personality and leadership ability, often it will be necessary to insist that pupils refrain from activities under some of these circumstances. On the other hand, there may be requests for excuse when the program, facilities, or teacher do not come up to desirable standards. Because of these varying factors each school must, with the cooperation of the medical adviser, principal, and physical educators, work out the plan best suited to its particular circumstances.

When private physicians give evidence of the need for modification or excuse from physical education for their patients, the school should make every effort to fit its program to the needs expressed by the physician. Occasionally, schools may receive what they consider unjustifiable requests for these types of adjustments. These may arise because the school personnel does not know all the details of the case or because the private physician is not being fully informed of the purposes and procedures of school physical education. Difficulties of this type may be partly overcome by conferences, by telephone or otherwise, between school medical advisers and private physicians and partly by keeping physicians informed of the objectives of modern physical education programs. A school health committee composed of representatives of the schools and of the county medical society may be valuable in developing procedures helpful to both the school and the practicing physician.

Protecting the Preadolescent from Inappropriate Activities

The health protection of pupils requires measures to prevent excessive strain or exhaustion from unlimited amounts of activity and from activities inappropriate for their age. This is particularly true of the rapidly growing adolescent or preadolescent pupil. While vigorous activity is stimulating to normal, healthy persons, excessive amounts may result in exhaustion and chronic fatigue. Recognizing the dangers involved in the overstimulation of immature boys in the elementary and junior high schools, the American Association for Health, Physical Education, and Recreation passed the following resolution in April 1938:

> Inasmuch as pupils below the 10th grade are in the midst of the period of most rapid growth, with the consequent bodily weaknesses and maladjustments, partial ossification of bones, mental and emotional stresses, physiological readjustments, and the like, be it therefore resolved that the leaders in the field of physical and health education should do all in their power to discourage interscholastic competition at this age level, because of its strenuous nature.
>
> Be it further resolved that where school systems continue to foster a program of interscholastic sports competition for pupils below the 10th grade, that they be urged to limit it to pupils who are physiologically mature as measured by Roentgen pictures of the degree of carpal bone ossification, advanced chronological age plus beard growth, or some other such indication of physiological maturity.[4]

In keeping with the above recommendation, most schools limit interscholastic competition to pupils in Grades X, XI, and XII.

Special Precautions for Girls' Athletics

The protection of girls participating in physical education demands that jumping activities be limited, for physiological reasons, and that body-contact games be omitted. As stated previously, all girls' activities should be under the supervision of women teachers, with women officials and special girls' rules. The Section on Women's Athletics of the American Association for Health, Physical Education, and Recreation has done much to encourage a high type of athletics for girls. Its report, *Standards in Athletics for Girls and Women,*[5] should be on the bookshelf of each high school. These standards, quite naturally, condemn such developments as the promotion of football for women, in the same manner as the following resolution of the American Association for Health, Physical Education, and Recreation:

> WHEREAS, a set of rules and a plan of organization and promotion for a game called "American Football for Women" have been published and sold in sporting goods stores; and
>
> WHEREAS, the game has received considerable publicity through motion pictures and certain pictorial magazines; and
>
> WHEREAS, the game has been originated and organized by men and is being promoted by men on the basis of the most intensive competition

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[4] Journal of Health and Physical Education "Two Important Resolutions." (Editorial.) *Journal of Health and Physical Education* 9: 488; October 1938.

[5] American Association for Health, Physical Education, and Recreation, *op. cit.*

> including "national championships" and the naming of an All-American Team; and
>
> WHEREAS, severe bodily contact and injury may well occur in this game, in spite of the ruling out of the tackle; and
>
> the dangers of commercialization and of exploitation of girls and women in this game are extreme, due primarily to the fact that these practices are already well established in connection with the game of football,
>
> participation of girls and women in the game of football is not in harmony with the main purpose of the athletic program for women as stated in the "Standards" of the National Section on Women's Athletics, i.e., "the good of the participant,"
>
> *Therefore be it resolved*, That the Association go on record as opposed to the development of the game of football for women and that it give all possible publicity to this resolution among groups which are in any way concerned with the welfare of girls and women.[6]

The exploitation of girls' athletic competition for commercial and publicity purposes is to be condemned. Commercialized sports contests are conducted for purposes other than the best interests of each individual girl and frequently result in overemphasis on winning, detrimental health effects, and undesirable social outcomes. The efforts of schools to prevent exploitation of girls in athletics are supported by parent-teacher associations,[7] as well as other groups with social or health interests.

The greatest value will be obtained from physical education only when proper safeguards are taken to protect girls taking part in athletics, when girls' athletic programs are properly supervised, and when commercial exploitation is prevented.

The Health of Boys Playing on Interscholastic Teams

Because senior high-school boys playing on interscholastic teams are frequently under considerable emotional strain, as well as because of the strenuous nature of their physical activity, it is important that special precautions be taken to protect their health. Perhaps the most important measure is for the board of education and school administrative staff to adopt and publicize a policy which calls on physical education teachers to consider the health of boys and their sportsmanship of greater importance than the winning of games. Such a policy will obligate them to see that all teams during practice sessions and games are under the direct supervision of qualified teachers. It will also obligate them to see that no team plays without the protection afforded by suitable equipment. Football injuries certainly can be minimized by seeing that each player has a helmet of good quality as well as hip pads and shoulder pads. In a similar way it is apparent that severe injuries may occur in baseball where the protection afforded by a catcher's mask and chest protector are missing. Naturally, the teacher in charge of teams will be expected to instruct pupils in the proper use of protective equipment. He will also be expected to give thoro instruction in the fundamentals of games because this instruction may be a factor in reducing accidents. It will also be his responsibility to see that the intensity of activity at the beginning of the season increases gradually and that boys "warm up" before each practice session or game. School liability for accidents is discussed in Chapter XVI.

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[6] Adopted by the Legislative Council, April 1940, on file in the office of the executive secretary of the American Association for Health, Physical Education, and Recreation.

[7] Journal of Health and Physical Education. "It May Interest You to Know —." *Journal of Health and Physical Education* 12: 384, June 1941.

At games, and also at practice sessions, the teacher in charge should give particular attention to those showing signs of fatigue and to those experiencing minor injuries. A pupil showing unusual fatigue should be immediately withdrawn from a game. Likewise, any pupil who becomes unconscious or dazed during a game should not be allowed to re-enter but should be referred to a physician. The best practice is for the board of education to have on the field at all football games a school medical adviser who has absolute authority to decide whether or not boys may enter a contest and when they should be removed. The teacher in charge should work in close cooperation with the physician, making available to him his special knowledge of individual boys. A pupil injured in athletics should be given first aid by either the school medical adviser or physical education teacher and then referred, if necessary, to his private physician or clinic for further treatment. Procedures for caring for accidents are presented in Chapter XI, "Injuries and Emergency Illness."

The health protection of boys in interscholastic athletics, as well as interest in their general welfare, requires that the number of games played each season be limited and that practice sessions be limited in length and frequency. This need has been rather generally recognized. Specific recommendations on this subject are contained in a report of a Committee on Interscholastic Athletic Standards for Boys of the City Administrative Directors of the American Association for Health, Physical Education, and Recreation.[8]

An excellent series of recommendations covering interscholastic athletics and other phases of physical education is contained in a booklet published by the New York State Department of Education, entitled *Regulations of the Commissioner of Education Governing Health and Physical Education.*[9] Among the recommendations contained in this report are the following:

1. That no post-season games or post-season tournaments other than those conducted by school authorities in accordance with approved standards be permitted.
2. That interschool athletic activities for boys be limited to competition between high-school teams, composed of boys in Grades IX to XII inclusive.
3. That interschool competition in football be limited to seven games.
4. That interschool competition in basketball be limited to a maximum of sixteen scheduled games a season, exclusive of sectional games.
5. That interschool competition in track be limited to a maximum of five meets a season, exclusive of sectional competition.

A number of cities, including New Rochelle, New York, Springfield, Massachusetts, and Hartford, Connecticut, have prepared statements of policies concerning interscholastic competition which include many provisions for protecting the health of participants. It is recommended that superintendents of all schools having interscholastic competition ask that secondary-school principals and physical education teachers cooperatively prepare written policies for this part of their program with due consideration given various factors affecting the health and safety of pupils.

State Athletic Championships and Interscholastic Boxing

The effect of state athletic tournaments on the health of boys deserves careful study and consideration by school medical advisers, school administrators, and physical educators. Particularly where there is considerable travel followed by a series of games with but short intervals of rest, the physical strain may be excessive. In addition, consideration should be given to emotional factors which, because of the tension of crucial games and the excitement produced by large audiences, may cause greater fatigue than that resulting from usual games. The protection of pupils requires that schedules and tournaments be arranged so as to promote health rather than dissipate it.

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[8] Committee on Interscholastic Athletic Standards for Boys. "Interscholastic Athletic Standards for Boys—A Committee Report." *Journal of Health and Physical Education* 10, 371-74, 423; September 1939.

[9] New York State Department of Education. *Regulations of the Commissioner of Education Governing Health and Physical Education.* Albany, N Y.: the Department, May 1940. 23 p

Because of health factors, and for other reasons, the American Association for Health, Physical Education, and Recreation discourages state championship contests. In April 1940 the Legislative Council of that organization adopted the following resolution:

> WHEREAS, there seems to be a growing tendency to promote state championships in interscholastic sports for both girls and boys, and
>
> WHEREAS, there seems to be sufficient evidence that the winners of these championships do not necessarily represent the teams deserving these honors, and
>
> WHEREAS, there seems to be but little doubt that the participants are being exploited by "outside" factions, and
>
> WHEREAS, there seems to be no evidence that the receipts of such contests are being diverted into educational channels, and
>
> WHEREAS, there seems to be a growing tendency to permit these contests to disrupt the school day,
>
> *Be it therefore resolved:* That the A.A.H P E R. encourage the elimination of all interscholastic State Championship Contests for both boys and girls.
>
> *Be it further resolved:* That the A A H.P E R. seek the assistance of the National Federation of High School Athletics in gaining the above objective [10]

In conjunction with the resolution on state championships, the Association passed another resolution expressly condemning interscholastic boxing. This reads as follows:

> WHEREAS, there seems to be an increasing tendency to promote interscholastic boxing in some communities and on the part of some individuals, and
>
> WHEREAS, boxing on a highly competitive basis is known to be potentially dangerous to the safety and welfare of boys participating;
>
> *Be it therefore resolved·* That the American Association for Health, Physical Education, and Recreation recommends the discontinuance of interscholastic boxing for boys eighteen years of age or younger;
>
> *Be it further resolved.* That this Association shall encourage all school administrators to immediately take steps to eliminate boxing from their interscholastic athletic programs.[11]

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[10] On file in the office of the executive secretary of the American Association for Health, Physical Education, and Recreation

[11] Adopted by the Legislative Council, April 1940, on file in the office of the executive secretary of the American Association for Health, Physical Education, and Recreation

These various resolutions have been enacted in the interests of protecting the health and safety of high-school boys participating in interscholastic activities. They deserve the wholehearted backing of school administrators.

Posture Education thru Physical Education

Education relating to posture and posture defects has always been a part of school programs, but changing views on this subject have brought about different emphases in teaching and different procedures in caring for those with posture defects.

The old concept of a rigid, static, uniform, upright posture has given way to the idea that individuals have innumerable different postures depending on changes in activity. In other words, we now think of posture as something dynamic, changing from moment to moment and requiring continual adjustments between different parts of the body. Because of developmental factors, the standards for good posture for high-school pupils are considerably different from those for kindergarten children. Similarly, there are differences in standards due to race and body build.

Presentday teaching emphasizes the esthetic value of posture rather than its effect on health; it states that good posture is desirable because it is a social asset. While not overlooking the effect of poor posture in causing fatigue or the symptoms which result from some cases of poor posture, this viewpoint recognizes that many minor deviations from either mechanical or esthetic standards of good posture have comparatively little effect on health. Mechanical interference with the functioning of the heart or lungs, frequently emphasized in past years as a detrimental effect of poor posture, is now considered likely only in pronounced cases.

Every pupil needs to know what good posture is, why it is desirable, and the interrelationships of nutrition, fatigue, heredity, and mental attitude with bodily posture. While physical educators will give leadership in this program, it should be a responsibility of all teachers to consider the posture of their pupils thruout the day.

Some schools select pupils with poor posture and immediately schedule them for special corrective programs of physical education. This unscientific approach does not recognize the many things which could cause poor posture; it considers poor posture an entity rather than a symptom. In preadolescent children poor nutrition is frequently the condition which produces poor posture, and consequently the treatment is the improvement of nutrition rather than exercise. In a similar manner, poor posture at any age level may be a result of fatigue, infection, emotional attitudes, or a congenital defect of bone or muscle.

Because of the variety of conditions which may cause poor posture, the first step in helping a pupil is to study him as an individual, making use of the health examination, teachers' observations, and knowledge of home conditions. From such a study, information may be obtained concerning the reasons for his poor posture and a rational program inaugurated for his care. This program may include additional rest, an adjustment of the amount of schoolwork or out-of-school work, treatment for infections or correction of remediable defects, a program directed toward improving nutrition, or a program of special exercise. The study of individuals and the preparation of plans to meet their particular needs should be the foundation of school efforts to help pupils with poor posture.

Girls' Activities during Menstruation

With the onset of puberty in girls, schools are faced with the question of what changes should be made in girls' programs during the period of menstruation. Should girls be excused from physical education during menstrual periods or should they be encouraged to continue their usual programs? What should schools do for girls with painful menstruation? Should changes be made in bathing and swimming programs?

Most girls desire to continue participation in usual types of activities during the time of their menstrual periods, and there is no reason why they should not do so. In fact, the continuance of regular activities wherever possible is beneficial rather than harmful and is helpful in developing the concept that menstruation is not sickness but is a normal, biological phenomenon.[12] Excessive, fatiguing activity is not advised, nor is sports competition in which there is a considerable emotional element in addition to the strenuous physical activity.

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[12] Bell, Margaret *The Doctor Answers Some Practical Questions on Menstruation* Washington, D C · American Association for Health, Physical Education, and Recreation, a department of the National Education Association, 1939. 9 p. (Planographed.)

Girls should omit swimming in pools during menstrual periods, but regular bathing should be continued. In years past, some people held the fallacious opinion that bathing during menstruation was harmful, but it is now known that there are no harmful effects from bathing and that baths may be continued thruout the entire period, provided water of body temperature or slightly warmer is used and that the bathroom is suitably warm.

Painful menstruation is an individual problem requiring medical care, and one which sometimes taxes the sagacity, wisdom, and patience of specialists. It is known that emotional attitudes are important and that at times a sympathetic, informative discussion of the function and mechanism of menstruation will have a beneficial effect. This is particularly true with girls whose mothers have failed to prepare them for this epoch in their development. Nutritional status and general physical condition are believed to be important factors; consequently, efforts to improve general health thru adequate food, rest, and recreation may help the girl with menstrual difficulties. In some cases, the difficulty may be due to disturbances of the endocrine glands; in others medication may be needed; and in still others surgical procedures.

From the point of view of physical education, girls occasionally experiencing pain and discomfort should be excused from activity and, if necessary and possible, a rest period substituted. Those who regularly request excuse because of pain should be referred to their physician. If they have no regular physician, the school nurse or school medical adviser may give information regarding facilities in the community for examination and treatment.

So-called "corrective exercises" have been suggested for the treatment of painful menstruation. While these have been reported effective by some, it is believed they should be taken only on the recommendation of a physician, following a study to determine, if possible, whether exercise is the best form of treatment or whether the condition should be treated otherwise. Because the condition may result from a number of different causes, no single type of treatment can be recommended for all cases.

Recreation and Education

Closely related to programs of physical education are programs of recreation, and like physical education recreation makes a definite contribution to the present and future health of pupils. Recreation is that which we do voluntarily for our own enjoyment and satisfaction. For some, recreation will be active; for others, passive. For some, it will be an individual activity; for others, a group activity. Regardless of the type of activity or the manner of participation, the fundamental outcome of recreation is enjoyment.

Education is concerned with recreation because it sees in recreative activities opportunities for pupils to learn. The pupil whose recreative interest is stamp collecting gains enjoyment from trading, arranging, displaying, and comparing his collection. But, in addition, his interest creates an ideal learning situation, and his hobby promotes a wider understanding of geography, history, printing, and other topics related to philately. In a similar manner, a hobby in photography, athletics, dramatics, wood-carving, debating, or music may be the beginning of wide exploration and study with great educational outcomes, as well as intense satisfaction and joy.

In 1918 "education for worthy use of leisure time" was included as one of the seven cardinal objectives of education. More recently the Educational Policies Commission has considered the development of recreational interests as part of the objective of education which has to do with the fullest development of the potential capacities of each individual—the objective of self-realization. In speaking of recreative arts, this group expressed the opinion: "A shallow respect for false and harmful 'standards' has in the past kept the recreative arts in the place of the poor relation. It is time to place them in a position of honor at the educational table." [13]

Perhaps presentday educational interest in recreation is due to an increased recognition of the responsibility of education to equip pupils with interests, attitudes, and skills useful in living as contrasted with making a living. Concentration on so-called academic subjects for the sole purpose of preparing pupils for more education seems to be slowly giving way to the demand that pupils be given a preparation for life. Increased thought given to preparation for life will undoubtedly result in more definite planning for, and greater prominence of, school recreational programs.

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[13] National Education Association and American Association of School Administrators, Educational Policies Commission *The Purposes of Education in American Democracy*. Washington, D. C.: the Commission, 1938, p. 67.

While consideration of the effect of recreative skills on the future leisure-time activity of pupils has been a factor centering attention on the need for this phase of education, we must not limit our attention to the future. Because boys and girls need recreation while they are still boys and girls, our plan for it must include forms which have immediate presentday value, as well as those useful for the leisure time of adult life. Probably teaching boys and girls how to participate in and enjoy the recreative activities of childhood is the best possible preparation for their participation in recreative pursuits in later life.

Increased recognition of the mental hygiene value of the absorbing interest and emotional release of recreative activities has given impetus to increased education for recreation. Presentday work for many industrial employees is a dull, emotionless repetition of monotonous movement. The shoe craftsman of past years, for example, took pride in his creation because he started with unfinished leather and ended with a product which bore his name and was a mark of his workmanship. In contrast, the machine operator in a modern shoe factory does but a single operation and knows not where or to whom the finished product goes. He has no opportunity for creativeness, for expressing individuality, or for joy of accomplishment. In his after-work time he must get these things.

In a similar way, other workers must work at high speed, under continual tension and excitement. They also need in after-work hours relaxation, wholesome recreation, and a change in activity. Social changes, quite fortunately, are supplying workers with increased leisure time. It is important that education prepare individuals for its wise use.

The particular contribution of recreation to mental health is the provision of interests thru which the individual will gain an integrated personality. The mentally healthy person is one whose behavior shows a unity of feeling, thought, and action. Such behavior is found in recreational activities where action is unified with attitudes reflecting emotional reaction and study, and thought representing intellectual effort. Absorbing interest, pleasure, and an opportunity for expression make recreative activities an ally of mental hygiene.

When personality development and character are considered objectives of mental hygiene, the contributions of recreation to mental health assume increased importance. Under wise leadership, recreation is a constructive force in molding group patterns of behavior and favorably influencing personality development. These factors make the selection of leaders particularly important. From another point of view, supervised recreation in favorable surroundings acts as a substitute for less desirable—possibly degrading and devitalizing—forms of recreation. The boy or girl interested in club activities, sports, or dramatics may find the time absorbed by that program so great that none is left for loafing or delinquent behavior.

Activities of Many Departments in Education for Leisure Time

The development of interests and skills useful for leisure-time activity is a responsibility to be shared by all parts of the school program. Physical education makes important and increasingly recognized contributions in the realm of sports and games for leisure-time use. Each year we find teachers in this field giving additional emphasis to the skills of activities which have leisure-time value. One of the important objectives of intramural athletic programs, sports days, and sports clubs is to provide recreation and to develop interests and skills which will be useful in later life. We would, however, have a narrow view of recreation if we limited it to sports, games, and big-muscle activity.

Education in music or participation in a choral club, a band, or an orchestra may create an appreciation of music and provide the basis for leisure-time enjoyment, both in school years and later. Art classes at school may be the beginning of a hobby of sketching, painting, or art collecting. Science classes may ignite the spark which kindles a lifelong interest in radio or photography, and a lifelong interest in reading may be started in literature classes. Indeed, there is no department of our presentday schools which cannot contribute to recreation.

In thinking of recreative interests and skills we frequently center our attention on after-school, so-called extracurriculum, activities. It is quite true that many of the clubs of high schools sow the seed of recreational interests and hobbies. The members of a chess club, orchestra, badminton league, stamp club, or other similar group are banded together by a mutual interest and a desire to further their knowledge and skill in a particular field. In many cases these interests and skills result in an interest which is sustained long after school years. However, despite the value of extracurriculum activities in this area, the curriculum itself, in regular school hours, should also contribute to education for leisure time.

Proficiency Contributes to Enjoyment

For the enjoyment of most forms of recreation a reasonable degree of proficiency is needed. An individual need not be expert to enjoy tennis, but he does need sufficient proficiency to afford a reasonable chance of winning a game.

Likewise, reasonable skill in piano playing will afford considerable pleasure even tho the individual be far from expert. We enjoy doing the things we do well. Consequently, the inculcation of attitudes toward recreational activities must be coupled with opportunities for developing some degree of proficiency.

In considering the proficiency needed in recreative activities, emphasis should be placed on the need for only a fair amount of skill. In other words, recreative activities should not be taken so seriously that individuals avoid participation if they do not excel. It is not necessary to rationalize participation in a hobby or sport; one should participate merely for the joy derived therefrom. To make a job out of one's recreation defeats the purpose of recreation.

Proficiency in activities requiring motor skill and coordination is best developed in the formative years of childhood. Swimming, golf, piano playing, and similar activities may be learned in adult life only with considerable effort and rarely with the success which accompanies similar learning in childhood. During school years children should have opportunities to learn the basic skills of a variety of recreational activities.

Community Recreation Programs Needed

The need for community recreation is broad. Curriculum and extracurriculum activities may develop interests and fundamental skills, but much more is needed if recreational needs are to be met. For school children there is need for after-school, Saturday, and vacation programs. And in addition to programs for school children there is need for recreation programs for the preschool and post-school ages. A picture of what may be done is presented by the Educational Policies Commission in the statement that follows.

> In many communities, school authorities have incorporated play and other leisure activities into the program at pre-school, in-school, and post-school levels The nursery school and kindergarten devote much emphasis to arts, crafts, and simple games all designed to help the child become adjusted to living in a group Elementary and secondary schools supplement the program of physical education with the study of art, music, dramatics, shopwork, and use of the library, designed to inculcate useful leisure-time appreciations and skills. For the out-of-school youth or adult some school systems offer arts and crafts, music, dramatics, shopwork, sports, games, dancing, discussion groups, and library service These recreation objectives are achieved not only through the use of the school building but also through utilization of such community facilities as parks, botanical gardens, zoos, and museums.[14]

Many areas of the school plant may be used for recreation purposes. Shops may be used for woodworking and metal groups; gymnasiums, playgrounds, and swimming pools are suitable for sports clubs and games; the auditorium is useful for recreative programs in dramatics and music; laboratories may be used for photography clubs; and classrooms may be made available for meetings of various types. These facilities, as well as all other facilities possessed by the community, should be available for general recreation purposes. Communities have too much invested in school properties to limit their use to the hours school is in session; they should be used afternoons, evenings, and during vacation periods.

The development of an all-round, all-year, recreation program for citizens of all ages is a community responsibility. The schools have a big share of this responsibility because, as outlined previously, the entire school curriculum and many school facilities contribute to it. Schools may, in fact, give leadership and provide personnel and administration for the entire community program.

Where outside groups such as park departments or recreation commissions share responsibility for administering the recreation program, there is need for some way to facilitate cooperative action. This plan may be a recreation commission with representatives of various groups interested in or concerned with recreation. The superintendent may well take the lead in developing such commissions in communities in which they seem desirable or necessary.

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[14] National Education Association and American Association of School Administrators, Educational Policies Commission *Educational Policies for Community Recreation*, Washington, D C.: the Commission, 1940 p 17-18.

CHAPTER VII

Mental Hygiene in the School Program

DURING THE PAST FEW DECADES there has been a rapidly increasing recognition of problems of mental and emotional health, together with an understanding of their extensive ramifications into all phases of life. Teachers are more and more interested in the personality development of their pupils;[1] schools are organizing guidance staffs, with counselors, visiting teachers, and sometimes guidance clinics; physicians are increasingly concerned with possibilities for the prevention and treatment of mental disorders and defects; lawyers and clergymen are studying emotional factors relating to behavior; taxpayers are studying amounts spent on institutions for the mentally diseased and defective and wondering what preventive measures are available; and many parents are giving careful attention to the habit training of infants because they have learned that habits have a bearing on later behavior. These efforts are all related to mental hygiene. The diversity of professional groups concerned and their varied interests and approaches give an indication of the widespread purposes of mental hygiene.

Mental hygiene is interested in measures aimed at preventing mental diseases and defects, in the provision of treatment and care for the mentally sick or defective, and in the prevention of delinquency and crime thru educational and social measures. In addition, our presentday interpretation of mental hygiene includes an interest in personality development and the prevention of tensions, stresses, and strains which may not produce clinical disease or extreme social maladjustments but which do cause unhappiness, ineffectiveness, discontentment, or other evidence of maladjustment between an individual and his social environment.

The aim of mental hygiene, to help individuals develop integrated personalities so that they may adapt to the usual exigencies of life with feelings of competence and satisfaction, coincides with the view that education should provide experiences promoting growth in the direction of self-confidence, social adaptation, self-expression, and the facing of reality. Thus, from the point of view of schools, the phase of mental hygiene dealing with personality development is identical with some of the aims of education; both are directed toward the development of individuals capable of satisfactory living.

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[1] National Education Association, Department of Elementary School Principals. *Personality Adjustment of the Elementary-School Child* Fifteenth Yearbook Washington, D C : the Department, 1936 448 p

School interest in mental hygiene is a practical application of its much stated interest in the whole child. To a responsibility for children's intellectual development and physical health, schools are adding an interest in the emotional development of children. This attention implies recognition of the importance of attitudes in influencing learning and behavior and a realization that the way one feels is as important as how one thinks and acts. This need for considering and furthering the emotional development of children must be coupled with an understanding of the unity of the individual and the need for his feeling, knowing, and acting in an integrated manner. While we may dissect the child into mental, physical, and emotional components for convenience of discussion, we must work toward an integration of them in the individual.

How can schools apply the principles of mental hygiene? What school procedures need changing? What type of personnel is required? As a convenience in discussing these questions, school mental hygiene activities will be grouped under four general topics, namely: (a) the emotional and social environment of pupils, (b) adaptation of school programs to pupils' mental abilities, (c) identification and guidance of pupils with emotional problems, and (d) instruction relating to mental hygiene.

The Emotional and Social Environment of Pupils

The first responsibility of schools in the field of mental hygiene is to provide a social and emotional environment for pupils which will not only avoid those things known to have undesirable effects but will provide experiences known to contribute to desirable emotional development. Some of these definitely constructive experiences will be brought out in considering ways in which schools may produce desirable environmental conditions, and likewise some present practices which have undesirable effects will be pointed out and condemned.

School Administration and Organization

There are a number of phases of mental hygiene which relate directly to school administration and organization. The general philosophy of the school system, the manner in which curriculums are prepared, the selection and appointment of teachers, types of supervision, administrative attitude toward discipline, and school procedures in promotion and grade placement all affect the emotional health of pupils.

The superintendent of schools and school principals, as the direct-line administrative officials of a school organization, thru their attitudes and their methods have a great deal to do with the school mental hygiene program. As each classroom has an atmosphere reflecting the personality and philosophy of the teacher, so does each school reflect the individuality of a principal, and a school system that of its chief administrative official. The general policy of the administrator may be one which encourages teachers to develop programs centering around the growth and personality of individual pupils or it may compel teachers to follow rigid programs emphasizing the memorization of factual material with little consideration of its relation to the growth of pupils. The first step in a school mental hygiene program is for administrative officials to promulgate policies and procedures indicating their interest in the all-round growth of pupils in contrast to subject mastery.

A second and extremely important administrative responsibility in the school mental hygiene program is the development of procedures contributing to the mental health of teachers because teachers are the most important factor influencing the emotional and social environment of classrooms and contribute most to the mental health of pupils when they themselves are emotionally healthy. Selection and appointment of teachers must be on the basis of merit with no elements of political pressure, personal friendship, or prejudice. It follows that tenure should be based on continued satisfactory service. Provisions for retirement in old age and for sick leave add to teachers' feelings of security. Administrators should protect teachers from community prejudices which prevent teachers from participating in the normal, wholesome, social life of the community. Salary schedules must be in keeping with compensation paid others in the community with comparable training, experience, and responsibility. All these administrative measures significantly affect teachers' feelings of security, adequacy, happiness, and self-respect and thus the character of their work with children (see Chapter XIV).

Among other administrative measures influencing the feelings of teachers toward their work are the methods used in curriculum construction and the methods and attitudes of supervisors. A rigid, specialist-prepared curriculum which the teacher is expected to follow regardless of pupil needs or pupil interests tends to mechanize his program, emphasize subjectmatter, and ignore personality development. To foster teaching which places progressive growth above isolated units of knowledge or skills requires a flexible program, with opportunities for teacher initiative. The flexible curriculum places upon the teacher responsibility for adapting programs to the needs of pupils but at the same time gives her freedom to meet a challenging task in the manner best suited to her abilities. This opportunity for initiative and this planning for her individual group give the teacher an increased appreciation of the importance of the work she is doing and an added feeling of usefulness to society.

Methods of supervision affect the emotional atmosphere of the classroom because they are related to teachers' feelings of adequacy, security, and happiness. Modern methods of supervision are directed at teacher growth thru methods which protect the self-respect of teachers and emphasize cooperative teacher-supervisor activities. Thru positive, constructive, and friendly help the supervisor respects the personalities of teachers in the same manner teachers respect the personalities of pupils. Dictatorial, supercritical, belittling forms of supervision are as much out of place in the school giving consideration to mental health as the horse and buggy on modern highways. It is the responsibility of administrative officials to provide teachers with the best available supervisory help and to provide administrative machinery permitting both teachers and supervisors to work effectively, cooperatively, and enthusiastically for the progressive growth of children.

Administrative attitudes toward discipline influence the relationships between pupils and teachers of all classes. Does the school administrator condone corporal punishment? Is misbehavior to be followed by routine, retributive punishment or is the pupil in trouble considered one to be studied and helped? Only when administrative staffs consider behavior as symptomatic evidence of basic attitudes, desires, and urgings is it possible for a school to deal intelligently with problems of discipline. Behavior must be studied not only from the point of view of its annoyance to the teacher but with a knowledge of how it is affected by home conditions, group attitudes, physical health, inherited tendencies, past experiences, and other factors. A program of school mental hygiene requires that disciplinary problems be approached with a determination to discover the underlying causes for undesirable behavior coupled with a sincere desire to help the pupil. This attention to the individual pupil can be given only with administrative backing and approval.

Consideration of the emotional and social atmosphere of classrooms requires that thought be given such factors in school organization as the grading of pupils, promotion methods, report cards, and homework. Much study has already been given to the effects of grouping pupils into grades, thus limiting school social contacts to those of close chronological age and implying that a group of children should all have identical experiences. As a result of these studies, some elementary schools are now breaking down the grade barriers of lower grades so as to permit participation in group activities by those of varying ages and to provide more individualized programs and greater opportunities for leadership and followership. The minimizing of grade placements in the elementary grades and less rigidity in promotion makes possible progress in accord with individual achievement and growth. Many changes in report card forms and the substitution of letters and conferences for more formal reports and arbitrary marks are further indications of school interest in the development of the whole child rather than solely in his acquisition of knowledge. In a similar manner the subject of homework is now considered in the light of what the child does during his entire day and its effect on recreative opportunities and participation in extracurriculum, home, church, and community activities. The abundant literature on all these topics in current educational periodicals and books testifies to educators' interest in organization procedures as they relate to personality development thru influencing the atmosphere of the classroom.[2]

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[2] National Education Association, Department of Supervisors and Directors of Instruction. *Mental Health in the Classroom* Thirteenth Yearbook, Washington, D. C., the Department 1940 304 p

§National Education Association, Department of Elementary School Principals, *op. cit.*

The Teacher and Teaching Methods

General policies of school administration, administrative procedures relating to teachers' welfare, supervisory methods, attitudes of superintendents and principals toward discipline, and general organization procedures indirectly affect the emotional tone of each classroom. But more direct than any of these is the influence of the teacher's personality, her teaching methods, and her understanding of the growth and development of children.

The personality of the teacher is quite likely a more important factor in the child's education than her technical knowledge. The emotional reactions of teachers cause similar emotional responses in pupils; the happy, tolerant, resourceful teacher is helping each pupil develop these same qualities. Further, the attitude of the teacher is important in developing the rapport essential for expression, creative activity, and social growth.

To exert favorable influences on the personality development of pupils, the teacher must consider her own emotional health. She must have the security offered by administrative measures mentioned previously, but in addition she must live a life which gives satisfaction coupled with a feeling of accomplishing something worthwhile. She must develop out-of-school interests, take a real part in community life, participate in a variety of recreative activities, maintain many social contacts, and take pride in the responsibility which her job entails. Thru her professional affiliations she can satisfy a need for identification with a larger group, a need closely related to maintaining one's self-respect. Thru complete living, the teacher develops broader vision, a greater understanding of human values, and a closer contact with the world at large. She gets more satisfaction and happiness from life, and in consequence she becomes a better teacher in the classroom.

From the negative point of view, the emotionally unstable teacher exerts such a detrimental influence on children that she should not be allowed to remain in the classroom. The teacher with an uncontrollable temper, or one severely depressed, markedly prejudiced, flagrantly intolerant, bitingly sarcastic, or habitually scolding may endanger the emotional health of pupils as seriously as one with tuberculosis or some other communicable disease endangers their physical health. Such teachers need help, but while they are being helped they should be out of classrooms so their pupils may be freed from the psychic injury, repression, and fear which their presence creates. There is need for educators and physicians to devise procedures for protecting children from inhibited, frustrated, distorted personalities.

Many factors influence the emotional tone of the classroom. The physical environment may be attractive, colorful, pleasing, and distinctive, or it may be drab, identical with all other classrooms, and depressingly void of decorations (see Chapter XII). The teacher's voice may be harsh, loud, and grating, or pleasing, inviting, and friendly. The way she dresses, and even the way she smiles—and we presume she smiles frequently—does something to pupils, either making them responsive, proud, and encouraged, or inhibited, despondent, and repressed.

The teacher interested in the mental health of her pupils recognizes their need for feelings of security. She sees that each pupil's special abilities are known to the group and she develops cooperative undertakings in which each pupil makes a significant, worthwhile contribution. She provides plenty of opportunities for pupils to experience the joy and happiness which should be birthrights of children. Tasks are assigned which, tho challenging, carry a reasonable opportunity for successful completion, because she is aware of the stimulating effect of success and the inhibiting power of constant or repeated failure. Fear is not used as a motivating factor because of its detrimental psychological effect. Pupils are given as much freedom as is consistent with the best interests of the group, and opportunities for expression and movement are numerous. In these various ways the teacher respects the personalities of pupils, thus helping them develop self-respect and self-confidence, and in a friendly, sympathetic manner she leads them toward increased independence, greater resourcefulness, and well-rounded growth. They develop a feeling of belonging to a group, and feelings of security and of happiness. They are growing emotionally, as well as intellectually and physically.

To accomplish most for the emotional development of pupils, teachers need a knowledge of children, factors influencing their growth, and general principles of mental hygiene. Teachers now in service should be familiar with recent publications dealing with these topics[3] while prospective teachers need to have this material presented in their teachers college courses.

Emphasis in teacher education should be placed on human behavior as contrasted with "regular" subjects. This changed emphasis may be brought about by substituting a study of mental hygiene and emotional behavior in the place of old courses, or by vitalizing courses now being offered in psychology, health education, or similar fields. Regardless of how it is done, it is important that prospective teachers gain a fundamental understanding of the "wholeness" of children and how educational experiences may help them develop all their potential capacities to the fullest degree.

As schools become concerned over the complete growth of children, they develop increased awareness of the importance of home and community influences on the education of children. This acknowledgment results in an understanding of the need for home and school cooperation. It follows that teachers find the necessity of knowing the home conditions of pupils, the advantage of teacher-parent conferences, and the need for parents and teachers jointly to develop plans for the benefit of children. Thru joint planning and joint action both parents and teachers expand their interests and significantly increase their contributions to the welfare of children.

Adaptation of School Programs to Pupils' Mental Abilities

An important phase of school mental hygiene is the determination of pupils' mental (intellectual) abilities and the subsequent adaptation of school programs to these abilities. This adaptation is important for both those with superior ability and those who are below average. The superior pupil may be definitely harmed by a program for average pupils because the lack of challenge and the development of slovenly work habits never prepare him for more difficult tasks.[4] The ease with which he accomplishes usual assignments may produce idle time which may be used in annoying, disrupting ways rather than in productive accomplishment. On the other hand, pupils with below-average intelligence faced with competition with those of "normal" intelligence will experience continued failure, with resulting feelings of inadequacy and incompetence. They may be continually nagged and exhorted to do things which their innate capacities make impossible. To avoid these undesirable developments, schools need a psychological testing program which will provide teachers with information concerning the intellectual potentialities of their pupils.

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[3] National Education Association and American Medical Association, Joint Committee on Health Problems in Education *Health Education* Washington, D C · the National Education Association, 1941. Chapter 4, "Facts All Teachers Should Know Relating to Child Growth and Development," p 40-73 ¶National Education Association, Department of Supervisors and Directors of Instruction, *op cit.* ¶McClusky, Howard Y, chairman "Mental Hygiene and Health Education" *Review of Educational Research* 10 403-527; December 1940.

[4] National Education Association, Research Division "High-School Methods with Superior Students" *Research Bulletin* 19 153-95, September 1941

Our knowledge of psychological testing has increased greatly during the past few years. We know now that psychological tests have substantial reliability and validity. But we also know that environmental and emotional conditions influence test results, that the rate of mental growth of children varies, that changes in intelligence quotients may occur over a period of years, and that most changes in mental status occur in young children.

Variations in intelligence tests indicate the need for careful interpretation and guarded prognosis. A standard psychological test, either group test or individual test, gives the teacher valuable, useful information, but it must not be considered infallible or unchangeable. Teachers should be informed of the various elements of the testing program and use information of special abilities revealed by the tests.

Because the IQ cannot be helpful in planning a program except as it is interpreted in the light of a pupil's age, teachers will generally find the MA (mental age) more helpful. For this reason all reports to teachers of the psychological testing of their pupils should include the mental age.

Experience indicates that factors influencing the validity of psychological testing include: (a) What test was given? Is it a standardized test with reliably established norms? (b) Who gave the test? Was it someone specially trained and experienced? (c) When was it given? The more recent the test, other things being equal, the more valid the results. These factors need consideration by all who use test results.

The type of psychological testing possible will depend on the size of a school, the preparation of teachers, the availability of a psychologist, and other factors. Group testing is found to be economical and practical, but in addition to group tests there should be resources for individual testing. Individual testing should be conducted by a trained psychologist. Regardless of the type of test or the person giving it, pupils should not be allowed to fail because attempts were not made to discover their intellectual capacities.

Those found to be mentally retarded—but not feeble-minded, requiring institutional care—need an educational program which will help them become healthy, happy, and useful members of their community. Despite intellectual limitations they have the same physical and emotional needs and urgings as other pupils. They need physical health, good character, and feelings of security, usefulness, and self-respect. Thru programs suited to their needs and abilities, schools can prepare them for happy, socially acceptable living; without suitable school experiences they may become unhappy, delinquent, criminal, rebellious, or dependent.

The plight of the mentally retarded adolescent is particularly deplorable. At this period, his physical development is marked by the onset of puberty, and he is no different from his classmates in this respect. Emotionally he has the same feelings to express, the same craving for approbation, the same sensitivity to criticism and failure. He, like others in his class, may be sensitive, jealous, happy or depressed, jubilant or morose. But altho he is similar to his classmates from the physical and emotional point of view, intellectually he may be only ten or twelve years old. Despite this limitation, some high schools still provide him with nothing but a college preparatory program. They provide subjects which prepare him for more education rather than for living; and usually this is because of tradition, administrative indifference, false pride in academic measures, or ignorance of the effects of such programs on boys and girls. A few years after terminating their high-school careers, either following graduation or previously because of discouragement, disinterest, or possibly school advice, these mentally retarded youngsters will be active citizens in the community. They will be voting for various officials, including members of the board of education; they will be members of social and civic groups; they will be marrying and raising children. Cannot the school devise a program which will help them assume responsibilities for citizenship, for making a living, and for parenthood? These are the essentials in a program for the retarded.

3.WATER FLOWERS. ELVA
4.PICK UP PAPER. ROBERT
5.DUST. VIRGINIA
6.HANG UP COATS. DON
7.CLEAN DESKS. JACQU
GREENHILLS
Y BUILD

HEALTH INFORMATION—*One part of the school's health program is to provide information. Too frequently in the past this has been the limit of the school's efforts. In better schools isolated facts, unrelated to child interests and needs, have steadily given way to an integrated program of vital activities.*

Photograph by
Greenhills (Ohio) Public Schools

Mentally retarded pupils, when they leave school, will be living in a world made up of all types of individuals. Consequently, during school years provision should be made for them to have social contacts with those of varying intellectual abilities and of their own chronological age. Special class placement may be desirable with some groups, for example, those with IQ's from 50 to 70, but such placement should be resorted to only when a satisfactory program cannot be provided otherwise Where special class placement is necessary, provision should be made for pupils to have some contact, either in school or out of school, with pupils of different intellectual capacities.

Mentally superior pupils also present the question of whether they should be enrolled in special classes or given an "enriched" program in a regular class. As pointed out previously, the ease with which the usual age-grade program is achieved by one of superior intelligence may lead to lazy work habits or misbehavior. Advancing a superior pupil, thus removing him from contact with those of his own age and placing him entirely with those of a different chronological age, different social development, and different social interests, may create a social misfit. Placement with others of superior ability may result in difficulties in adjusting to average persons, feelings of snobbishness, and exaggerated feelings of importance. Because of these considerations, a common adaptation now suggested for a pupil with superior mental ability is an enriched curriculum in his usual age-grade class. This curriculum involves extra independent projects, special readings and reports, and more difficult sections of assignments. It is prepared by the teacher with a view to challenging the imagination and ability of the student, requiring him to exert himself, and developing habits of application, creativeness, concentration, and continued effort. Without programs adapted to the varying abilities of pupils, a school cannot completely fulfil its responsibilities in the field of mental hygiene.

Identification and Guidance of Pupils with Emotional Problems

From the point of view of children's behavior problems, the phases of school mental hygiene previously discussed may be considered preventive efforts. The administrative and teaching factors affecting the social and emotional atmosphere of the classroom are directed partly toward adequate personality and social development and partly at the prevention of emotional problems. Likewise, adapting educational experiences to intellectual capacities is one measure aimed at preventing undesirable forms of behavior. These preventive aspects of school mental hygiene are extremely important, but what is the school to do about those exhibiting emotional problems or social maladjustment? Does the school have any responsibility for the shy, withdrawing type of pupil who never mixes with other children, expresses himself only when forced, daydreams, and has no outside interests? Can the school do anything for the pupil who lies, masturbates, or steals? What can be done for the pupil who has average or better than average intellectual ability but whose achievement is below average? Our modern concept of school mental hygiene places upon schools the responsibility for identifying these evidences of social and emotional maladjustment and for devising and instituting plans to help such pupils.

There are a number of reasons why this phase of mental hygiene is a function of the school. First, it must be recognized that some maladjustments may be due to school programs; there may not be the environmental conditions which permit the pupil to make a satisfactory school adjustment or he may be asked to accomplish more than his capacities permit. Second, and closely related to the preceding, the treatment of a maladjusted pupil may involve school procedures regardless of whether the cause is something within or outside the school. Frequently the treatment of emotional and social maladjustment involves participation in group activities either as part of the regular school program or as part of a recreation program. Third, the treatment of emotional problems is essential if pupils are to gain most from their school programs. They cannot do good work if worried, depressed, unhappy, or emotionally upset.

A fourth reason for school acceptance of responsibility is that the school has the privilege of contacting greater numbers of children than any other agency. It is known that many adult maladjustments are sown in childhood, and the school has a better opportunity than any other group of detecting these early evidences of emotional difficulty. Finally, the objectives of education cannot be achieved for an individual pupil if emotional maladjustments are not corrected. The school has not done the best job possible if a pupil leaves school with an excellent knowledge of language or mathematics but also has emotional attitudes of jealousy, inferiority, or inadequacy which later result in discontentment, rebellious quarreling with co-workers, or marital unhappiness. Nor has its program been satisfactory if its salutatorian graduates with fears or conflicts of feelings which later cause neurotic complaints and eventually an unhappy life and unsuccessful career. The purposes of our democratic program of education require that pupils with evidences of maladjustments be studied and helped as a means of aiding them to live more satisfactorily today and to remove, if possible, attitudes which if continued will produce serious conditions later.

It should not be assumed from the foregoing that the teacher or other member of the school staff is to assume responsibility for the psychiatric treatment of emotional problems. Such is not the case. But members of the school staff may, thru a broader acquaintance with mental hygiene, select pupils to be referred to appropriate agencies or individuals for further study and treatment. And they may give guidance to those whose problems center around school adjustment or whose maladjustment is such that educational, recreative, or social measures rather than psychiatric treatment are needed. It is difficult to draw the line between those cases which may be treated by the school staff and those which should be referred to psychiatrists or child guidance specialists. But as in the field of physical health the layman administers first aid, then refers to the physician cases which are severe or unusual, so also in the field of mental health unusual or severe cases require the advice of a specialist.

The identification of pupils with emotional problems is usually not a difficult procedure because many evidences of maladjustment are noticeable to the teacher. The pupil who is disinterested, antagonistic, unhappy, deceitful, easily embarrassed, or the one who lies, steals, or commits sex offenses is usually known to the teacher. Unfortunately, however, studies have shown that many teachers consider minor infractions of arbitrary school rules, such as talking, note-passing, and moving from one part of the room to another, as evidences of undesirable behavior while not giving adequate consideration to the shy, docile, retiring type of pupil. From the psychiatric point of view the latter is considered much more serious. While most teachers are aware of emotional problems among children, the following list of characteristics may be suggestive of pupils requiring study and help:

1. Overstudious, docile, and withdrawing
2. Bullying, overaggressive, and domineering
3. Unhappy and depressed
4. Overexcitable; uncontrollable emotions
5. Stuttering
6. Lack of confidence, self-denying, and self-censure
7. Poor accomplishment in comparison with ability
8. Lying (imaginative or defensive) and lack of appreciation of property rights (stealing)
9. Masturbation, abnormal sex interests, sex offenses, sex notes
10. Antagonistic, negativistic, continually quarreling.

As teachers gain increased knowledge of children, of emotional attitudes influencing behavior, and of mental hygiene as related to children, the problem of identifying children needing help will not be difficult.

The first step in helping a pupil with a behavior problem is a study of the entire child. What is his physical make-up and physical condition? What is his intellectual ability and what type of work has he been doing? What are the social factors in his life? What are his own attitudes toward his problems and his behavior? Without information from all these fields no intelligent approach can be made to his problem. Behavior is not solely the result of inheritance or physical health and emotional attitudes, nor of home and community conditions, nor of intellect and school adjustment, but a result of an interplay of all these influences. If we are to help the individual we must know him and we must know the home, school, and community environment to which he must adjust.

Sometimes the study of a pupil has valuable therapeutic results. It gives the school a better understanding of the perplexities, handicaps, and burdens which a pupil faces, and thus encourages tolerance, sympathy, and understanding. It helps the school discover adaptations which it should make in its own purpose and program. The opportunity afforded a pupil to discuss his troubles with a sympathetic, understanding person is an important part of the study. It gives him a feeling of relief and a clearer understanding of his problem and possible solutions to it. Further than this, it leads him to feel he has a friend, that there is someone willing to understand him and help solve his problems. This may change not only his attitude toward school but his attitudes toward society, toward his problems, and toward life in general. In these various ways the study of a pupil and friendly teacher-pupil conferences utilize two duly fundamental devices in mental hygiene: (a) making adaptations in the environment, and (b) giving the individual insight into his problems and changing his attitudes toward them.

Teachers are faced each day with many situations demanding a knowledge of the principles of mental hygiene. Some of these situations have been outlined recently with suggestions for dealing with them in a practical, effective, and helpful manner, in a booklet entitled *Mental Hygiene in the Classroom.*[5]

Different schools will use different procedures in helping pupils with emotional problems. In many schools the only one available for this will be the classroom teacher. Her knowledge of mental hygiene may be limited and she may have had no training or experience in making studies of children. Nevertheless, unless she undertakes the task it will not be done. In other schools, counselors with special preparation in guidance, including mental hygiene, will be available. His special preparation, together with provision of time for special conferences, frequently permits the counselor to conduct a more complete study than could the teacher. This complete study is possible, however, only where the counselor is not overloaded with routine procedures, such as checking absences, course requirements, and class scheduling, and where he is not identified as an official responsible for discipline. The counselor needs time for repeated, sometimes lengthy conferences if he is to be a vital force in helping pupils with their emotional and social problems.

During recent years the visiting teacher has become an integral member of many school staffs and has contributed much to the understanding of children's emotional problems and ways of helping them.[6] The term "visiting teacher" should be limited to the trained psychiatric social worker whose training includes mental hygiene and case work subsequent to successful teaching experience. This background of experience in both teaching and social work makes the visiting teacher an invaluable aid in the study of pupils and the development of constructive school mental hygiene programs. Her work is most effective when she has available for consultation a psychiatrist who has specialized in child guidance work. In many situations, the visiting teacher acts as an adviser and helper to teachers in the study of pupils with emotional problems, rather than as one to whom the teacher refers a case and then feels relieved of all responsibility. In working with pupils the visiting teacher will utilize the subject or classroom teacher's continuous daily contacts with the pupil for both observation and help.

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[5] National Education Association and American Medical Association, Joint Committee on Health Problems in Education. *Mental Hygiene in the Classroom* Washington, D C : the National Education Association, 1939 70 p.

[6] American Association of Visiting Teachers *Visiting Teacher Service Today* San Diego, Calif the Association (Sec Mary Nicholls, Bureau of Child Guidance, City Schools), 1940 21 p (Planographed)

Some large school systems have organized, or have available in the community, child guidance clinics where the services of a psychiatrist, psychologist, and social worker are available. This group is ideal in the consideration of the whole child and his whole environment; we should look forward to the time when the services of such a group are available to all children who need them, either thru the school system, if it is large enough to warrant it, or thru a consolidation of a number of schools, or on a township, county, or district basis. The end results of social and emotional maladjustments in children are so costly that an amount spent on child guidance clinics would eventually save the community many times that amount. Prevention is better, and also cheaper, than care.

Instruction Relating to Mental Hygiene

School health instruction programs should include topics related to mental hygiene. While it is important for pupils to learn about nutrition, care of the eyes and ears, measures for the prevention of disease, and other subjects usually found in health instruction programs, it is equally important that older pupils learn something about the factors contributing to mental health and what their communities are doing to prevent mental disease and to care for the mentally defective and mentally sick.

Health instruction relating to mental hygiene can be directly related to many phases of instruction. In connection with instruction concerning physical health it can be pointed out that physical health and mental health are interrelated and that sound physical health is a foundation stone for building mental health. In home economics classes, and in other classes where family life is discussed, the influence of home life on personality development and emotional health can be brought out, with particular reference to the detrimental effect of broken homes on children's emotional development and the positive value of children's early habit training. Physical education classes may discuss the relationship between recreation, hobbies, and mental health, the need for play, the need for rest, and the social values of games. Classes in literature offer innumerable opportunities for discussion of personality development and the relationship of social factors to emotional health, because novels now included in courses of study contain many illustrations of incomplete and inadequate personalities as well as examples of the effect of different types of environment and different social situations on the emotional life of individuals. Thru efforts of this type, instruction relating to mental hygiene may be integrated with practically all subjects in the school program. To be most effective this type of instruction needs to be presented tactfully with due regard to pupils' home situations and social background.

In addition to the material on mental hygiene which may be integrated with various subjects, it is desirable for schools to consider the possibility of some direct instruction on this subject by a teacher especially trained in health education. This may be part of a regular high-school course in "Healthful Living" or "Modern Health Problems," or it may be a separate special course organized for the particular purpose of stimulating and directing study of problems of mental health. The latter procedure was followed in some Delaware schools where an experimental course in "Human Relations" was presented to seventh-grade pupils in fifteen weekly periods of from fifty minutes to one hour each. Commenting on this experimental instruction in mental hygiene, H. Edmund Bullis of the Delaware State Society for Mental Hygiene writes:

> That children, or even adults, do not learn much regarding their personal emotional problems as a result of didactic teaching or lecturing is generally believed to be true Most of our insights regarding our emotional life are obtained through personal experience, through being in close contact with well-adjusted people. Although it is difficult to provide in the school room the actual emotional experiences desired, an attempt has been made in these human relations classes to provide as near to "actual experiences" as is humanly possible. Shy children are encouraged to participate more freely in stimulating social relationships. After the first few classes, almost all of the children voluntarily discuss in the

> class emotional experiences they have had They bring out in the open matters that have at some time been perplexing and worrying them.
>
> Through the use of specially edited sound-movie films from Hollywood productions it is possible, after the showing of the film depicting certain emotional problems of adolescent youth, to get the children to discuss in a lively fashion the reasons they attribute for the actions of the youngsters in the film. The participation of the children in the spontaneous discussion is almost the same as their actually having had the experience depicted in the picture Frequently, very personal experiences are given by the students in their contributions to the discussion. Not only sound films, but also plays, stories, personal anecdotes, newspaper accounts of current events, edited case studies, recorded dramatizations, panel discussions, and debates have been used successfully as stimuli for discussion[7]

Another phase of mental hygiene can be presented in courses dealing with community organization and activities. In this there could be discussed community measures for caring for the mentally sick and defective; community education regarding the causes, treatment, and prevention of disease and defect; community resources for psychiatric treatment and child guidance; and community recreation facilities.

In education relating to mental hygiene, particular emphasis needs to be placed on the need for sympathetic, kindly treatment of those with mental problems and the improved outlook due to our growing understanding of the causes and treatment for these problems. Mental disease and defect should not be regarded as a disgrace, any more than having pneumonia or appendicitis. There are many kinds and degrees of mental disease, some amenable and some resistant to currently known methods of treatment. These facts, if presented thru health education, should lead to a more sympathetic attitude toward those afflicted and encourage them to seek medical advice and treatment at the earliest development of abnormal symptoms. As with other forms of disease, it is an advantage to have treatment instituted before the condition becomes advanced.

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[7] Bullis, H. Edmund, "Mental Hygiene for Normal Children" *Delaware State Medical Journal* 13: 128; June 1941.

CHAPTER VIII

School Programs for Physically Exceptional Children

IN EACH SCHOOL SYSTEM, some children are to be found who cannot be fitted into the regular program of the school because of physical handicaps. It is the responsibility of the school superintendent to make special arrangements for them, either by providing special facilities within the system or by seeking outside assistance. There is no school system which does not contain such children.

The types of children who are most likely to need special educational facilities are as follows:

1. Deaf and hard of hearing
2 Blind and partially sighted
3 Crippled
4. Speech defective
5. Undervitalized
6. Cardiac
7. Tuberculous
8. Epileptic

The presence in the school district of children with severe physical disabilities is often not known to the local school authorities because of the failure of parents to inform the superintendent. These children are often forced to grow up illiterate, ignorant, and unable to take their places in society. Family pride, ignorance, or sometimes plain shiftlessness is the cause; only by taking the initiative himself can the superintendent make sure that each child in his district has a proper education.

In locating the physically exceptional child there is no adequate substitute for a house-to-house school census. A census that is made by having the teacher query the pupils or by asking the parents to take the initiative in making a report is not adequate Each home must be visited by a representative of the school. Such a census requires excellent organization, but if properly organized it does not require an undue amount of labor.

The problem of placing physically exceptional children in special schools or special classes is often vexing. Some persons feel that to remove a child from a regular classroom is to brand him as an abnormal child. Others argue that every physically exceptional child should be removed from the regular grades to prevent his having to compete with children who are not handicapped.

A good general rule to follow is to enrol a child in a regular classroom if his physical condition permits and if he can get a sound education there. If his condition requires constant medical supervision, or if he is apt to do himself injury, he must be enrolled in a special class. If his condition requires it, special teaching procedures can be provided by enrolment either in a special class or in a regular class with part-time special teaching.

Because of the difficulty later in life that physically exceptional children are apt to have in economic competition, the school program for them must include both vocational training and vocational placement. The remarkable achievements of physically handicapped persons who have been properly educated serve as an inspiration to the superintendent who is faced with the necessity of providing special facilities for an exceptional child.

Deaf and Hard-of-Hearing Children

Deafness in young children is often not recognized. Even total deafness may not be noticed for some years after birth. A deaf[1] child will feel vibrations and will react to them, which may lead a casual observer to believe that the child can hear but is stubborn.

Deafness has a profound effect upon the intellectual development of the child, and a deaf child is often mistaken for a feeble-minded child who would not profit from an education. Such children are sometimes placed in an institution for the feeble-minded without an examination of either their hearing or their intelligence. As a consequence, a child with great educational possibilities may be allowed to become a permanent ward of the state, in no wise able to contribute to his own welfare. It is an important rule that no child should be considered deaf or hard of hearing or feeble-minded until both his hearing and his intelligence have been carefully examined.

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[1] It is customary to distinguish between "deaf" and "deafened" children "Deaf" children are those who are born without hearing. "Deafened" children are those who lose their hearing sometime after birth. In this chapter, however, the term "deaf" will be used to refer both to "deaf" and to "deafened" children

Finding Deaf and Hard-of-Hearing Children

An adequate school census will disclose the presence of the totally deaf children in the district. Locating them is usually a much simpler problem than that of picking out, from among the children who are enrolled in school, those who are sufficiently hard of hearing to require special facilities.

There are two general methods by which hard-of-hearing children can be found. One consists of the informal but careful observation of the children for such symptoms as the following:

1. Inattention when the speaker is not seen
2. Inability to answer easy questions
3. Habit of asking to have questions repeated
4. Turning one ear toward the speaker
5. Picking at the ear
6. Faulty pronunciation, unnatural pitch of the voice.

The other method consists of the examination of all children by the school nurse or teacher. There are three commonly used procedures for making such examinations. One is the watch test, in which the ability of a child to hear the ticking of a watch held at varying distances from each ear is measured. A second is the whisper test, in which the ability of the child to repeat what he has heard whispered at varying distances is determined. Both of these are useful for making preliminary studies where the audiometer is not available. The third procedure involves the use of an audiometer. One type of audiometer makes use of phonograph records and earphones. Each child hears in his earphone a series of numbers which decrease in loudness until he can no longer hear them. The child writes all the numbers he can hear. As many as forty children can be tested at one time. The other type of audiometer can be used with only one child at a time. It provides the most accurate picture of the hearing disability. In his earphone the child hears a pure tone which is made progressively soft or loud by the examiner. He is tested at each octave or half-octave from a point well below the pitch range of speech to a point well above the speech range. By this means a chart, called an audiogram, is filled out for each ear separately.

It is customary to use an audiometer of the first type for testing all the children and one of the second type for retesting the children shown by the first test to have a hearing disability.

Modifications of the School Program for Deaf and Hard-of-Hearing Children

Depending upon the seriousness of the hearing disability, children should be placed in three groups: (a) special schools or classes for the deaf, (b) special classes for the hard of hearing, and (c) regular classrooms with some adjustment made in the program.

Special schools or classes for the deaf—A child whose hearing loss is so profound that he cannot be taught thru his ears must be educated as a deaf child, even tho he can hear some sounds. Only a few of the largest cities have found it feasible to establish special schools or classes for their deaf children. Other school districts must utilize state-maintained schools. Enrolment should be made as early as possible—preferably at the kindergarten level. This is sometimes difficult to accomplish because parents hesitate to give their permission. Nevertheless, early enrolment is essential if the child is to be properly educated because the processes of developing a vocabulary, learning to read lips, and learning to speak are very time-consuming.

Special classes for the hard of hearing—A child who has a marked hearing loss but who can nevertheless gain information thru his ears should be placed in a special class for the hard of hearing. The class should meet the following standards:

1 The maximum class size should be ten or twelve pupils. Classes of fewer children are sometimes necessary.

2 The teacher should have special training in teaching lip reading, in speech correction, and in methods of teaching the usual school subjects to the hard of hearing

3 Electrical hearing aids should be available.[2] These are usually of the type which permits the child to plug his earphone into a circuit with the teacher's microphone at any place in the room. Individual aids are much more expensive but have the advantage that they may also be used outside the classroom A wide assortment of visual aids is also essential

4. In addition to the usual school subjects, training must be given in the interpretation of sounds, in lip reading, and in speech.

5 It is necessary to use specialized teaching methods, especially in the language arts

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[2] A list of satisfactory hearing aids may be obtained from the Council on Physical Therapy of the American Medical Association, Chicago, Illinois

The hard of hearing in schools for the deaf—Considerable harm can be done to the hard-of-hearing child by enrolling him in a school for the deaf and educating him as if he were deaf. He is apt to think of himself as deaf, to develop the mannerisms of the deaf, and to fail to use the hearing he possesses. Placement in such a school should be made only when the school maintains entirely separate classes for the hard of hearing which meet the standards established for such classes in the public schools.

The hard of hearing in the regular classroom—When circumstances do not permit the enrolment of a hard-of-hearing child in a special class, the regular classroom should be made to provide as good a learning situation as possible. A hearing aid should be made available by the school or by a local charitable organization if the parents are unable to provide one. The child should be seated in the front of the room near the windows. From this location he can see the teacher and the other pupils, with the light from the windows upon their faces. This will enable him to read lips more easily. He should be encouraged to turn and look at the speaker. If at all possible he should be given instruction in lip reading by the regular classroom teacher, by the speech correction teacher, or by an itinerant lip-reading teacher.

Blind and Partially-Sighted Children

Totally blind children are so easy to recognize that it seems strange any should be overlooked. When this happens, it is usually the fault of the school census or of a school administrator who either does not know the proper procedure to follow in providing an education for the child or who lacks the proper initiative. Partially blind children are more difficult to recognize and frequently are enrolled in school without realization of their need for special education.

Finding Partially Blind Children

A blind child cannot see clearly even momentarily. Partially blind children usually can see if conditions are right. The book may need to be six inches from the eyes, or three feet. The pupil may have to contort his face, guide his eyes with his finger, dry his eyes, or walk to the blackboard, but usually he can see clearly, momentarily, if he is permitted to do so.

Even so, he may have trouble with vision. Over extended periods of time he may see double, things may blur, or his eyes or head may ache. Such conditions are frequently the cause of irritability, of dislike for school, of reading disabilities, and of unpleasant personalities.

The ability of the child to see for short periods is fairly well measured by means of the Snellen chart. This chart has rows of letters ranging in size from large to small, to be read at a distance of twenty feet. The use of this chart, preferably by the school doctor or nurse, is an excellent first step in a search for children with defective vision.

However, such a chart will fail to disclose the child who is unable to see comfortably over long periods. Defects of fusion and of muscular balance are the commonest, altho not the sole, causes of such discomfort. Children who possess these can be located either by the observations of the teachers or by the use of specially constructed tests.

The careful day-by-day observations of the pupils by the teachers should include looking for the following symptoms:

1. Red, inflamed eyelids or eyeballs
2. Frequent blinking and rubbing of the eyes
3. Tilting the head awkwardly
4. Holding a book very close to the eyes
5. Inability to read the blackboard.

The use of specially constructed tests, such as the Betts' test,[3] for fusion defects and muscular imbalances has been a relatively recent innovation in the school program. Some systems are finding their use a definite help. Others have found that the precautions with which the tests must be used make their application inadvisable under typical school conditions.

No child should be classified either as blind or as partially sighted solely upon the basis of the Snellen chart, the fusion and muscular balance tests, or the observations of the teachers. Such technics should be followed by thoro examinations by qualified specialists in every case in which a significant difficulty is found. Further guidance may be necessary as discussed in Chapter III.

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[3] Betts, Emmett A. *Visual Sensation and Perception Tests of the Ready to Read Tests* Meadville, Pa : Keystone View Co , 1934. (Revised 1936 and 1941)

Classification of Pupils on the Basis of Degree of Visual Defect

Pupils may be classified into three broad groups on the basis of their degree of visual defect. Classification is usually based upon the ability of the child to see, using both eyes or just his better eye, after he has been fitted with glasses. The final classification of a child as blind or partially sighted should be made by a qualified ophthalmologist.

Blind children are those who for all practical purposes have no vision, or who are barely able to see at 20 feet what the normal person can see at 200 feet. This is spoken of as 20/200 vision.

Partially-sighted children are those who have vision between 20/200 and 20/70 (the ability to see at 20 feet what the normal person can see at 70 feet) or who have other visual defects so serious as to require special school procedures.

Regular classroom children are those whose vision is better than 20/70. They may have visual difficulties but the school does not need to provide any special program for them.

The School Program for Blind Children

In general, there are two ways in which blind children can be educated. One is instruction in the regular classroom, with special attention in reading and writing Braille and in typewriting. The other is enrolment in the special school or special class. Each method has certain advantages and disadvantages.

The special school is able to offer the child more highly specialized materials, methods, equipment, and teachers. A larger library of books in Braille and of maps in relief is usually available. The vocational training program can be more diversified and specialized. The physical education program can be modified to teach the child to use his body and to have grace and confidence. The teachers can be expected to have more insight into the personal adjustment problems of the blind child.

On the other hand, the special school usually requires that the child live away from his own home. Only the largest cities can maintain a school for the blind; most children must be enrolled in state-maintained schools. In some instances such separation is beneficial because of bad home conditions. In other instances parents refuse to permit the child to leave home for sentimental reasons.

The enrolment of a blind child in the regular classes enables him to remain in his own home and permits him to associate with other persons who are not blind. This constant association with normal persons is usually good mental hygiene. However, not many school systems are able to provide a teacher of Braille. When they do, the teacher usually travels from building to building thruout the school system, teaching one or two children at a time since the problem of transportation makes it difficult to bring all of them to a single school.

The School Program for Partially-Sighted Children

Partially-sighted children must not be educated as if they were blind. Neither should they be enrolled in schools for the blind. Such schools are not equipped to *conserve* vision; they usually present the worst possible reading conditions for partially-sighted children. Nor should partially-sighted children be taught Braille. It is virtually impossible to force a partially-sighted child to read Braille with his fingers. Unless he is blindfolded, he will try to read with his eyes, thus subjecting them to far greater punishment than if he were reading ordinary print.

The content taught partially-sighted children should be the same as for children with normal vision. Only the methods, materials, and general classroom equipment need to be modified. The following standards describe a satisfactory sight-saving classroom:

1 The methods of instruction should be suited to the needs of the pupils. Essentially, the sight-saving room is a homeroom in which lessons are prepared and reading done. The pupils go to their regular classrooms when feasible to recite and to participate in other activities that do not cause a strain on the eyes.

2. The teacher should be specially trained in eye hygiene and in the methods of instructing partially-sighted children.

3. The classroom must be equipped with sufficient indirect light to place 20 to 30 foot-candles on each pupil's desk, without shadows and without glare. Translucent window shades should be attached at the center of the windows, instead of at the top. They should cover the glass only when necessary to keep out direct sunlight. All furniture, walls, and floors should have a dull finish in order to avoid glare. Desks should be movable and should have tilt-tops to hold books at a proper reading angle. The blackboards should be of the nonglare variety Of course, these minimum standards for sight-saving classrooms are maintained, ideally, in the regular classroom for all children.

4. Books should be printed in large type on nonglare paper. So-called "clear-

type" texts are recommended. Maps should be drawn to a large scale, free from detail. Typewriters equipped with "jumbo" size type should be used both by the teacher and the pupils. Paper should not have a glossy finish.

5. The maximum class size should be twelve or fifteen pupils, depending upon the number of grades in the room. The larger the number of grades represented, the fewer is the number of pupils who can be adequately taught.

When it is not feasible to enrol a partially-sighted child in a sight-saving class, the program of the regular classroom should be modified to meet the special class standards as nearly as possible. It is especially important to have adequate light, freedom from glare, and large-sized type. The child should be taught orally as much as possible.

Types of Crippled Children

Crippled children are those who are not able to make normal use of their bones, muscles, and joints. Some of them are paralyzed; some of them are deformed in a way which prevents normal movements; and others are affected with a disease of, or an injury to, their bones, muscles, or joints. A child who is misshapen or dwarfed but who does make normal use of his body is not a crippled child and should not be educated as one. Such a child should be placed in a regular class and should be encouraged to think of himself as being an entirely normal child.

Finding Crippled Children

Except for locating those who have not been reported by their parents, finding the crippled children who require special school facilities is principally a medical problem. During the medical inspection the condition of the child should be diagnosed and the type of special education required should be determined. When the family physician of the crippled child reports a need for special education, the case should be given full consideration. It is well, however, to have an orthopedic specialist recommend the remedial procedures to be used, the amount of time each day the child may spend on schoolwork, and the special equipment, such as braces and furniture, which the child requires. The choice of school subjectmatter and the methods by which it is taught should be determined by the school superintendent or teachers rather than by the physician.

Some types of crippled conditions, especially those involving injury to the brain, are accompanied by mental retardation, which in some cases is great enough to represent feeble-mindedness. This makes a psychological examination of the crippled child necessary before a course of study is selected for him. Due consideration must be given to his limitations in evolving his school program.

Modifications of the School Program for Crippled Children

A mentally normal crippled child who does not need special medical supervision, who is able to walk either with or without braces or crutches, and who is not apt to suffer accidental injury by his classmates should be enrolled in a regular classroom. His teacher should think of him, and should encourage him to think of himself, as a normal member of the group.

When, however, the physical condition of the child makes it unsafe for him to be in a regular classroom, special facilities must be provided. These special facilities may take several forms:

1. *A special school, wherein children are graded as in a regular school*—A number of the larger cities have found it feasible to establish such special schools. They make it possible to provide full-time medical and nursing supervision, ramps and elevators instead of stairs, muscle-training equipment, heat and light treatment equipment, baths, cots for resting, balanced lunches, and special furniture. The larger number of children who will use the specialized equipment in a special school makes it easier to justify the necessary expenditure than would be true with a single class.
2. *An ungraded special class in a regular school building*—The number of crippled children in a district may be too small to justify a special school. In other communities, the problems involved in transporting the children to a central building may make single classes in different buildings preferable. In such a situation the crippled children are apt to have more contact with noncrippled children, which is usually desirable. However, it is not always possible to provide as adequate equipment or medical supervision in single class units as can be had in special schools.
3. *Special teaching in a hospital or convalescent home*—Providing school facilities in a children's hospital or convalescent home frequently works very well. The facilities provided will, of course, vary with the number of children and with their needs. At one extreme, a room adjacent to a ward may be permanently equipped with school supplies, a blackboard, maps, typewriter, and other equipment, and a full-time teacher. At the other extreme, a teacher voluntarily and without extra pay may go to the hospital after her regular teaching is over for the day and teach one or two children. For children who must be in a hospital for an extended period, especially those in tuberculosis sanitariums, the opportunity to continue their schooling is usually excellent therapy even tho their physical condition may permit only a small amount of time to be spent on lessons each day.

4. *Home teaching for the home-bound child*—Some children are home bound permanently or for extended periods They need to be educated, and the fact that they are unable to attend school does not take from them their right to a free education. An itinerant teacher, who visits the homes of five or six children daily, is often the only feasible method of making school training available.

5. *State-maintained residential school*—Altho it is customary for the states to maintain residential schools for the blind and for the deaf, it is sometimes argued that a similar school for the crippled is less desirable. It is true that no crippled child should be enrolled in a state-maintained residential school if it is possible for him to be educated in his own school district. There are, however, large numbers of home-bound crippled children in areas so remote that home teaching is not feasible. As a consequence, they do not have a chance to become educated. For such children, enrolment in a residential school is absolutely necessary if they are to receive the benefits of an education.

Transportation of crippled children—It is almost always necessary to provide transportation for crippled children. When the school district maintains its own buses and has its buildings equipped with ramps and elevators, the problem is greatly simplified. Some districts utilize taxis or bus companies; others make contracts with private individuals, usually parents of crippled children.

It is sometimes found best to employ an attendant who assists the children on and off the bus, into the building, and to the toilet. In some instances this may involve carrying the child. In the case of a single crippled child such service may be provided by the janitor or by a strong teacher. Local ingenuity can solve many a problem when the importance of an education to the child is realized.

Vocational education and guidance of crippled children—Because of the difficulty they are apt to have in economic competition, it is essential that the older crippled children receive an education distinctly vocational in nature. All states cooperate with the federal government in its program for the vocational education of the physically handicapped. The superintendent should make use of the services rendered for the benefit of the children in his district.

Speech Defects

The production of clear speech, which conveys meaning precisely and effectively, is a highly skilled art. It requires the working together of a large variety of muscles in widely scattered parts of the body. Many different factors may cause poor speech; some are under control of the speaker, whereas others are beyond his control.

In order to speak well a child must hear accurately; he must hear good speech, because all speech is imitative; he must not have any structural defects which will prevent him from imitating the sounds he hears; he must be free from emotional instability; and he must have a well-integrated nervous system. A program for the development of good speech and the correction of speech defects must, therefore, be a broad one, attacking the problem from a variety of angles.

Finding Speech Defective Children

At the time of entrance into school, many children have already developed speech defects; others develop them during their school careers. In order to locate the children who need special help, the regular classroom teacher should be asked to report upon the children in her class. Her report should be based upon her observation of the following types of defects:

1. Stuttering
2. Lisping
3. Baby talk
4. Nasality
5. Foreign or unpleasant local accent
6. Substitution of one sound for another
7. High pitched, guttural, harsh, or monotonous voice.

The average classroom teacher will be able to recognize many of these defects; others she will fail to observe. It will be necessary to have a speech specialist make a survey of all the children in the system if all who need help are to be located. It is possible for one person to examine about twenty or thirty pupils a day.

The Diagnosis of Speech Defects

Following the finding of the children who possess speech defects, it is necessary to have the nature of the defects diagnosed. This procedure consists of two aspects. One is the diagnosis of the underlying cause of the difficulty. For example, the cause may be defective speech heard by the child in his home, a partial deafness which prevents his hearing low tones, wide spaces between his front teeth, a lesion of the nervous system, or any one of a large number of other causes.

A well-trained speech correction teacher will be able to make an adequate diagnosis of the cause in a majority of the cases.

Occasionally, however, it will be necessary for her to refer the child to a speech clinic or to a medical clinic. A majority of the state universities and a number of the teachers colleges maintain speech clinics.[1] Some of them are mobile clinics, which will send a staff to the local district to make the diagnosis and to recommend treatment.

The other part of the diagnosis is the determination of the particular speech skill with which the child has difficulty. This aspect can be made adequately by the well-trained speech correction teacher without any outside assistance.

The Correction of Speech Defects

The correction of speech defects also consists of two aspects. As far as possible the causes must be removed. In a minority of cases this may require medical or surgical treatment. It may require the purchase of a hearing aid, or it may require that the child be motivated to imitate the speech of his friends and teachers rather than that of his parents. It sometimes requires the removal of personality conflicts. Such work must be done largely on the individual basis.

The other aspect of the process of correction consists of training the child to produce correct speech. This training can usually be given successfully in small groups meeting two or three times a week. Difficult cases will require individual attention. The necessary retraining may be provided either by an itinerant teacher who travels from school to school or by a speech correction center. The pupils should be enrolled in regular classrooms but should be excused from the regular work during the visit of the speech correctionist or during their visit to the speech center.

The itinerant-teacher plan makes it possible for the children to do all their work in one building and is usually the best plan for the milder cases which do not require elaborate equipment. Under this plan, one itinerant teacher can give adequate retraining to not more than seventy-five or one hundred pupils.

The speech center plan is usually more desirable for the severe cases. It makes possible the use of more highly specialized technics. Full-time speech classes or special schools for speech defective children are not recommended.

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[1] A list of these institutions is given in the Appendix of this yearbook, pages 397-98

Speech defects associated with other handicaps—It is not uncommon to find that children who are suffering from other types of handicaps also have speech difficulties. Mentally defective children, children who are paralyzed due to a birth injury, and deaf children, for example, are frequently in need of speech correction.

In some instances, it is possible to enrol such children in the regular speech correction classes. Usually, however, the nature of these defects makes a more highly specialized program necessary.

The Undervitalized, Cardiac, Tuberculous, and Epileptic

In addition to the types of physically handicapped children previously described, there exist other types which require special consideration in a school health program. These include the undervitalized child, the cardiac child, the tuberculous child, and the epileptic. Each of these types differs distinctly from the others, and each presents special problems, but at the same time they are alike in regard to certain desirable modifications of the school program.

The discovery of these children is distinctly a medical problem. They will be recognized by the medical officer in a well-conducted school medical inspection. Also, they will be reported to the schools by the family physicians. Unfortunately, however, many schools do not find it possible to have adequate medical examinations. Furthermore, many of the children come from underprivileged homes which cannot provide medical attention. Under such circumstances, all the resources of the community must be called upon to assist in the discovery and proper treatment of these exceptional children.

The Undervitalized

The child with lowered vitality may be suffering from malnutrition, fatigue, anemia, poor heredity, poor habits of living, or other conditions. He may have a relatively permanent condition which will last thruout his whole time in school, or he may merely be temporarily weakened following an illness. Whatever the basic condition may be, he does not possess the physical energy necessary for success in a full school schedule.

The majority of such children can best be educated in regular classrooms, with only simple modifications in the school program. The most frequently desirable modifications are as follows:

1. A shortened school day, with a reduced program of studies in which the essentials are stressed
2. Rest instead of exercise during recess and physical education
3. A warm lunch at noon and such other feeding as recommended by medical adviser or family physician
4. Visits to the home by the school nurse or visiting teacher to insure adequate food and rest and freedom from heavy household duties
5. Adequate ventilation and heating (also necessary in regular classrooms).

While the majority can best be cared for in the regular classroom when these modifications of the program have been made, there are some children whose conditions are so serious that they need to be enrolled in a special class. The old-fashioned, open-air classroom which was unheated even in the coldest weather is no longer advocated.[5] In its place has come a newer type with the following characteristics:

1. Adequate ventilation, but with reasonable temperature
2. Mid-morning and mid-afternoon rest periods, during which clothing is loosened and the children sleep on cots
3. Morning, noon, and mid-afternoon feeding, when prescribed
4. Transportation to and from school
5. A drastically reduced program of studies, which usually requires additional years in school to complete the minimum essentials
6. Practical instruction in personal hygiene and preventive care.

The enrolment of a pupil in such a class should be made only upon the basis of the findings of the family physician or the school health service. Transfer to a regular grade, with the suggested modifications of the program, should take place as soon as it is feasible. The aim of the special class should be to build up the energy of the child to the point where he can again take his place in a regular classroom.

The Cardiac

The cardiac child is one who is suffering from an abnormal heart condition. As a consequence, his school program must be modified to the extent necessary to avoid further injury and to permit recovery. As with the undervitalized child, the majority of the cardiac cases can best be enrolled in the regular grades. The modifications of the program found necessary for the undervitalized child may be needed for the cardiac as well. In addition, it is usually important for him to avoid climbing stairs. If no elevator is available, he must be placed in a ground floor room.

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[5] National Education Association and American Medical Association, Joint Committee on Health Problems in Education. *Open Air Classrooms.* Washington, D C.: the National Education Association, 1937 13 p

In more severe cases, and during acute conditions, it will be necessary for the child to remain at home in bed. If his condition permits, he should be visited daily by the teacher for the home-bound.

The Tuberculous

The tuberculous school child is usually suffering from the "childhood form" of the disease rather than from the "adult form." Whether he should remain in the public school or go to a sanitarium depends upon both the extent to which he is apt to infect others and the influence his school attendance will have on his own health. A child with a progressive form must undergo treatment which makes it impossible for him to attend public school. In this connection, the discussion of tuberculosis in Chapter X should be read carefully.

When the disease is in an apparently arrested condition and is not in an infectious state, the child should attend school. Depending upon the seriousness of his condition, he should be enrolled in a regular grade under the restrictions recommended for undervitalized children or, in more severe cases, in a special class for the undervitalized and cardiac cases.

While at a sanitarium, or undergoing treatment in his home, he should have the same school opportunities that are provided for the crippled child under similar circumstances. The likelihood of a complete physical cure is so great that no tuberculous child should be permitted to grow up without the benefits of an education.

The Epileptic

Epilepsy is a disease characterized by seizures. It takes many forms. Some types are subject to improvement and cure thru dietary and medical treatment; others are destined to be relatively permanent cases, sometimes accompanied by deterioration in the individual. In some, the seizures are slight and involve only momentary loss of consciousness. In others, the child loses consciousness, falls, and has extreme convulsions.

Children who are suffering from a mild form may be enrolled in the regular classrooms. When the seizures are extreme the effect upon other children must be considered and the epileptic child may need to be excluded. Epileptic children, however, are as educable as normal children. If they cannot be enrolled in school, they must be taught by the teacher of the home-bound, as is done in the case of crippled children. When it is necessary to place the epileptic child in a hospital, he should have the same educational opportunities that are provided for other hospitalized children.

The Estimated Number of Children for Whom Special Programs Are Required

The number of physically exceptional children to be expected in a school district will depend principally upon the effectiveness of the health program, and upon the educational and economic status of the citizens of the district. Wherever the health program is effective, and wherever the parents are aware of the need of their children and are financially able to provide proper prevention and care, the number of physically exceptional children will be greatly reduced.

In an average district the estimates made in Table 1 may be considered to be reasonable. These estimates may be used to determine the approximate number of children of any one type in a district. Divide the total number of school children in the district by the value given in the table for each type. The quotient will be the estimated number of that type in the district who require special attention.

TABLE 1.—ESTIMATED SIZE OF THE SCHOOL POPULATION FOR EACH TYPE OF EXCEPTIONAL CHILD IN THE TYPICAL SCHOOL DISTRICT

For one child of each type for whom a special program is required	Corresponding approximate size of the school population in the district
Deaf	1500
Hard of hearing	300
Partially sighted	2000
Crippled	300
Speech defective	40
Cardiac	150
Epileptic	1200

For example If there are 3000 school children in the district, there are likely to be 2 who are deaf.

The Organization of Special Classes

A number of national societies, interested in specific types of exceptional children, have published pamphlets which are very helpful in organizing special classes. Information concerning such topics as recommended equipment, costs, daily schedules of activities, and teacher-training institutions is available. Superintendents who are organizing classes for the first time should write to the following societies whose addresses and services are outlined in the Appendix of this yearbook: American Heart Association, American Medical Association, American Society for the Hard of Hearing, National Foundation for Infantile Paralysis, Inc., National Society for the Prevention of Blindness, National Tuberculosis Association, and the United States Office of Education. In addition to these, the following groups may be helpful: American Foundation for the Blind, Inc. (15 West Sixteenth Street, New York, N. Y.); American Society To Promote the Teaching of Speech to the Deaf (1537 Thirty-Fifth Street, N. W., Washington, D. C.); American Speech Correction Association (419 Boylston Street, Boston, Mass.); and National Foundation for the Blind (105 East 22d Street, New York, N. Y.).

CHAPTER IX

Communicable Disease: General Control Measures

PROTECTION AGAINST DISEASE is one phase of school health work upon which there is general agreement regarding the responsibility of the school. As long as the law, amply supported by public opinion, compels every child to attend school, the school must face the responsibility for protecting the child against preventable diseases which may be acquired in connection with the school program. Practical necessities extend this responsibility to varying degrees beyond the limitations of the physical property of the school.

In emphasizing the importance of the school in the control of communicable diseases, it is important not to overlook other community factors. The school is by no means the only factor or necessarily the principal factor in the spread of epidemic diseases, altho it is popularly so regarded. "The school age . . . is one . . . where the attack rate from communicable diseases is quite high, and where physical defects are common."[1] The school may be either a serious menace to the health of its children or an important factor in their protection, depending upon its organization and administration as regards the control of the communicable diseases.

Communicable diseases are often avoidable by the exercise of forethought and precautions. These precautions involve three principal factors which are: (a) the construction, equipment, and operation of the school plant; (b) the school program in its broadest sense; and (c) the personnel of the schools, including the school employees as well as the pupils.

General Control Measures

General control measures for communicable diseases include certain phases of construction, equipment, and operation of the school plant, and certain general policies with respect to exclusion of sick children from school, readmission after illness, and exclusion of exposed persons. Immunizing procedures, for the encouragement of which the school should take a certain responsibility, are always involved, as are opening and closing of schools in the presence of epidemics.

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[1] Mustard, Harry S. *An Introduction to Public Health.* New York: Macmillan Co., 1935. p. 220

Specific control measures vary for the different diseases. In the sections immediately following, consideration will be given to general control measures and policies. Specific measures directed at individual diseases are discussed in Chapter X.

Construction, Equipment, and Operation of the School Plant

"There can be no argument regarding school responsibility for a healthful environment. Pupils are required to attend school and the authority to compel attendance implies the responsibility to provide an environment conducive to growth, learning, and health." [2] Among the most important points in a healthful environment which contribute to the prevention of communicable diseases may be briefly enumerated the following:

1. Sufficient classroom, gymnasium, locker room, and playground space to avoid undue crowding
2 Adequate toilet and washroom facilities readily available to maintain the cleanliness of the hands which is most important in preventing the spread of the communicable diseases of childhood, and cleanliness of body which may influence spread of skin diseases and vermin
3. Proper ventilation and heating to prevent either rapid chilling or overheating of the body with consequent reduction of resistance to the communicable diseases
4. Pure water, drinking fountain with running water, as a safeguard against intestinal diseases such as typhoid, dysentery, and acute nonspecific intestinal infections
5. Use of pasteurized milk as a safeguard against milk-borne diseases
6. A system of exclusions and control of readmissions which will keep children suspected of communicable diseases away from contact with healthy children
7 Abandonment of emphasis on "perfect attendance" records of pupils
8. A policy toward teacher absences that will not put a premium on keeping teachers in school when they may be spreading communicable diseases, especially colds
9 Inspection by parents of their children each morning before sending them to school, to make sure that no evidence of acute illness is present
10. Training of the class teacher to recognize evidence of acute or chronic illness.

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[2] National Committee on School Health Policies. "Suggested School Health Policies." *Journal of Health and Physical Education* 11. 285; May 1940

The school plant has been mentioned here mainly for emphasis since it is covered more fully in Chapter XII.

Exclusions and Readmissions

"The experiences of children with communicable diseases and the way in which those diseases are prevented and controlled in the public school are in themselves educational. These experiences should be utilized in instruction. The health education program should develop sound knowledge and right attitudes toward immunization and make pupils intelligent, reasonable, and cooperative in communicable disease control." [3]

The *regulations* for handling the communicable diseases once they have been diagnosed should be enforced by the health department. The school itself must undertake to protect itself from these diseases and others by an effective system of continuous supervision. This supervision should be carried on as inconspicuously as possible so as not to disrupt the routine of the school. It can be carried out effectively without taking much time or constituting an undue burden on school personnel whose principal duties are administrative or instructional.

The *principle* on which general protection against communicable diseases is based is simple, namely, exclude all children with suspicious signs without waiting to establish a diagnosis. The suspected child should be sent, without delay, to a separate room in the school where study can be continued without endangering other children and remain there until the school physician or nurse inspects the child. It will be noted later that the common cold is the key to communicable disease control because its several symptoms may be present in one or more of the communicable diseases. Thus, a *cough* might mean a cold, measles, influenza, whooping cough, pneumonia, or bronchitis. Hoarseness might have similar significance. A *running nose* might be due to a cold, chicken pox, measles, German measles, influenza, or infantile paralysis. A *sore throat* might indicate a cold, scarlet fever, measles, septic sore throat, or diphtheria. A *skin rash* might be a simple flush accompanying a cold with fever or it might indicate measles, scarlet fever, German measles, or chicken pox, or one of the skin diseases, such as ringworm, impetigo, or itch. *Pain* may be present in the head, the throat, the chest, or the abdomen, or *fever* may occur in any of the diseases already mentioned and many more. *Nausea, vomiting, diarrhea,* or *constipation* might accompany any of the acute diseases of childhood. *Pallor, lassitude,* or *irritability* may indicate oncoming illness, possibly communicable.

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[3] Turner, C E. *Personal and Community Health.* St Louis. C. V Mosby Co , 1939 p. 498.

Several days frequently elapse before an identification can be made. In the meantime, the child exposes others if allowed to stay in school. A policy of prompt exclusion on suspicion, without waiting for definite diagnosis, is necessary to protect the schools against the spread of epidemics. Such a policy appears at first glance to be destructive of attendance records, but *experience proves the contrary.* It is true that many exclusions are made in circumstances where no major disease develops and the child is back in forty-eight hours. It is possible to make many brief exclusions without injuring the attendance record as much as it will be injured by two or three long absences due to a fully developed case of scarlet fever or other major communicable disease. Moreover, the short exclusions are useful even when no major disease develops because they tend to minimize if not prevent the spread of colds. Finally, and most important, no child can do good schoolwork when suffering from a cold or incipient disease and should, therefore, be at home for his own good. "When a pupil in school is suspected of having communicable disease, such as measles, scarlet fever, or chicken pox, he should be separated immediately from other pupils and arrangements made for sending him home. In addition to sending him home, it may be desirable to have the desk and other fixtures which he has touched washed with soap and water." [4]

To summarize, children should be excluded from school whenever they manifest any of the following symptoms:

flushing
repeated sneezing
sniffles
red or watery eyes
eyes sensitive to light
running nose
sore throat
listlessness
abnormal irritability
pallor
fever
nausea or vomiting
diarrhea
skin eruption
skin peeling
rash
pain
cough
dizziness.

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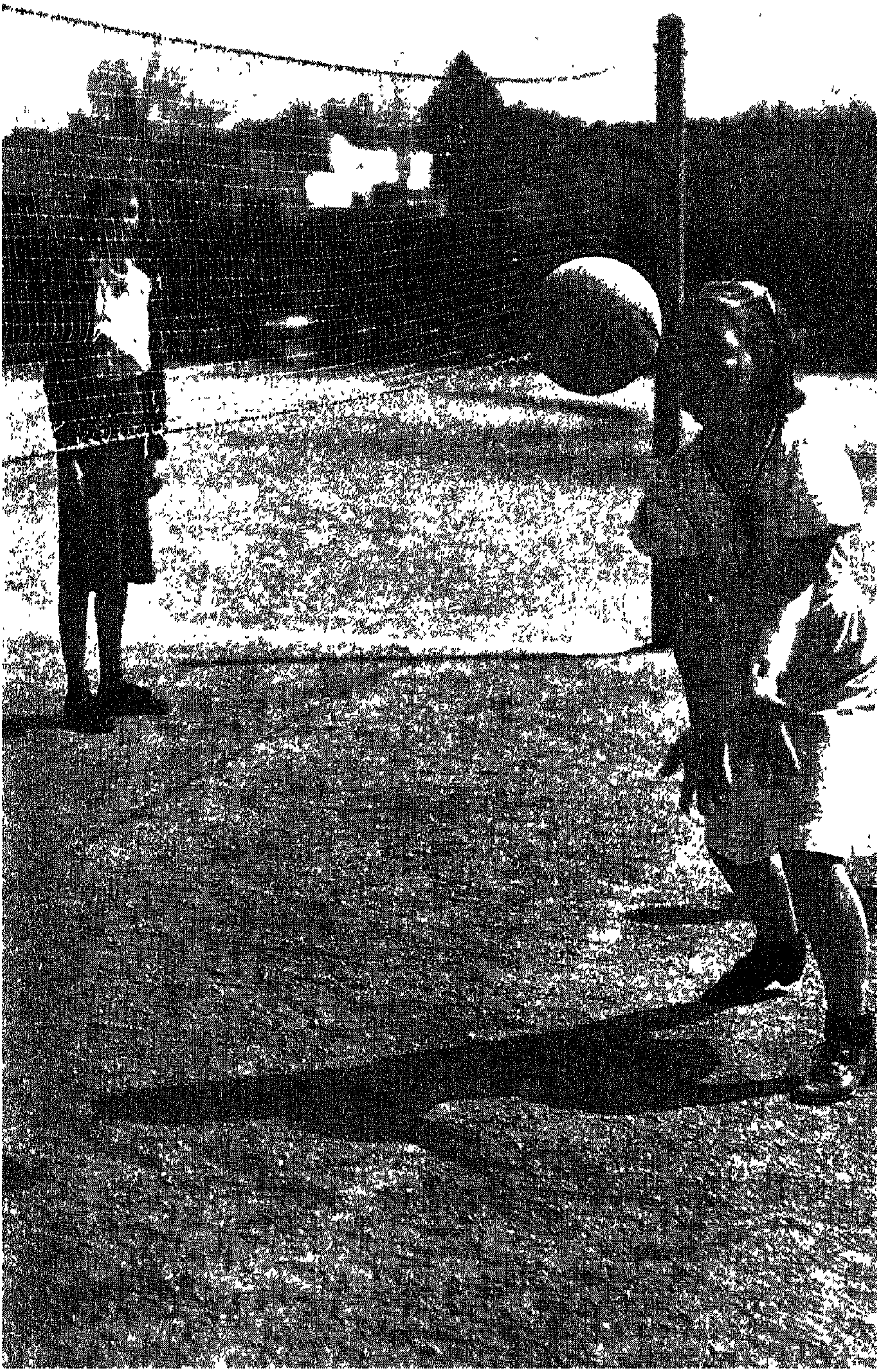
[4] National Committee on School Health Policies, *op. cit.*, p. 334.



PLAYING THE GAME—*Vigorous exercise helps to build mental and emotional stability. Self-control and sportsmanship developed thru games are among the school's contribution to successful living. Health education is one means whereby the school creates lifelong interests and habits.*

Photograph by
Los Angeles (California) Public Schools

When children have been excluded from school on suspicion of communicable diseases or when they return to school after illness, consideration should be given to whether or not it is safe to readmit them. Readmission policies will depend upon existing organization and health facilities. The following are mentioned in order of their desirability: (a) medical certificate from school medical adviser or family physician, (b) certificate from school nurse or health department, (c) note from parents, or (d) judgment of teacher or principal.

Immunizing Procedures

Most of the immunizing procedures which will be mentioned in connection with individual diseases should have been done before the child reaches school. As a matter of fact there will be large numbers of children, amounting in some communities to an overwhelming majority, who come to school having had no immunizations whatsoever. In addition, there are some immunizations which cannot be applied as mass procedures in anticipation of possible future exposure but must be applied between the time of known exposure and the possible development of the disease. Most questions relating to immunization are medical problems, but they have administrative and educational aspects which are briefly outlined here.

The most important, universally recommended immunization measure is vaccination against smallpox. It should be done during the child's first year of life, again upon entering the elementary school, and again upon entering the secondary school. In the meantime it should be repeated whenever the child has been exposed to smallpox unless a successful vaccination within the five years preceding exposure can be demonstrated either from the scar on the arm or from available health records. It is important to remember that a failure to "take" does not indicate immunity to smallpox. The school medical adviser should be asked to interpret to the administrators the significance of the three forms of vaccination reaction which are, briefly, as follows:

1. The successful vaccination, or "take"
2. The immunity reaction, a modified "take" which indicates persistence of immunity
3. The negative reaction, which indicates nothing but failure.

In the ideal situation, children would start school previously immunized against diphtheria, and Schick tests would have been given to verify their immunity. In actual situations, this is often not the case, and the school, therefore, should exercise leadership in cooperation with medical and health authorities to procure immunization against diphtheria in kindergarten and lower-grade children. Above the age of ten years, diphtheria immunization decreases in importance, and above the age of twelve it should be done only when advised by the family physician. Teachers occasionally get diphtheria, but adults should be immunized only upon the advice of the family physician.

Immunization against typhoid is highly effective but is not necessary as a routine measure in all circumstances. In communities with poor water supply or with milk which is not universally pasteurized, in rural areas, or where sanitation is poor, vaccination against typhoid should be done routinely. The duration of immunity is about three years. It requires three injections.

Vaccination against whooping cough should be done in infancy. By the time a child has reached school age there is little point in recommending it.

Immunization against measles is theoretically possible but not practically feasible. From the school administrator's standpoint it is necessary only to know that children who are weak or for some other reason liable to serious complications from an attack of measles should be referred to the family physician by the school medical adviser. This procedure will enable the family physician to immunize such children as he deems advisable by the use either of convalescent human serum or placental extract.

Immunization against scarlet fever is a procedure which the schools should leave to the judgment of the family physician. Such immunization can be performed but it is a procedure which belongs in the office of the family doctor. In general, it may be said that mass immunizations against scarlet fever do not seem to be advisable in view of the relatively mild character of the disease as now prevalent, the improvement of nursing and medical facilities, and the availability of a serum for treating the more severe cases.

Immunization against tetanus or lockjaw, if not previously performed in combination with diphtheria immunization (see "Tetanus" in Chapter X), becomes an emergency measure when injuries are sustained which carry with them the danger of infection with *tetanus bacilli.* This danger is present when there are punctured wounds or injuries involving considerable laceration and bruising, especially where street or playground dirt is involved. In this connection it may be pertinent to remark that athletic events or practice should not be held on fields where horses or cattle have been allowed to pasture.

Closing School for Epidemics

To close the schools or keep them open—this is one of the principal topics of discussion among school administrators and health officers. Traditionally, public opinion has been taught to expect and often to demand the closing of schools for the sake of controlling epidemics. Conditions change more rapidly than public opinion can follow them. Modern developments in public health procedure suggest a changed attitude toward the closing of schools (Figure X).

If schools are already in session and an epidemic develops, the decision as to closing the schools should rest largely upon the availability of resources for supervision of school children. It should be remembered that closing the schools leaves the children at loose ends and favors community contacts and dispersion of infection thru such channels as theaters, playgrounds, public conveyances, stores, and neighborhood contacts to a greater extent than would be the case if schools were open. On the other hand, keeping the schools open creates a definite hazard unless means are available to administer effectively a policy of close supervision and rigid seclusion as outlined previously.

If the schools are not yet in session and an epidemic begins, as is often the case in infantile paralysis, it may be desirable to postpone the opening of the schools for a few weeks. This is not the same as closing the schools, because if the schools have been open, school contacts have already been made and not as much is gained by closing the schools. If they have not yet been opened, the schoolroom and schoolground contacts can be avoided by postponing the opening.

Where school administrators are faced with public opinion based on misinformation which demands the closing of schools, the situation can usually be met most satisfactorily by agreeing to close the schools provided children are rigidly excluded from all public places and are kept on their own home premises. This paralyzing alternative usually convinces parents that a properly supervised school is as

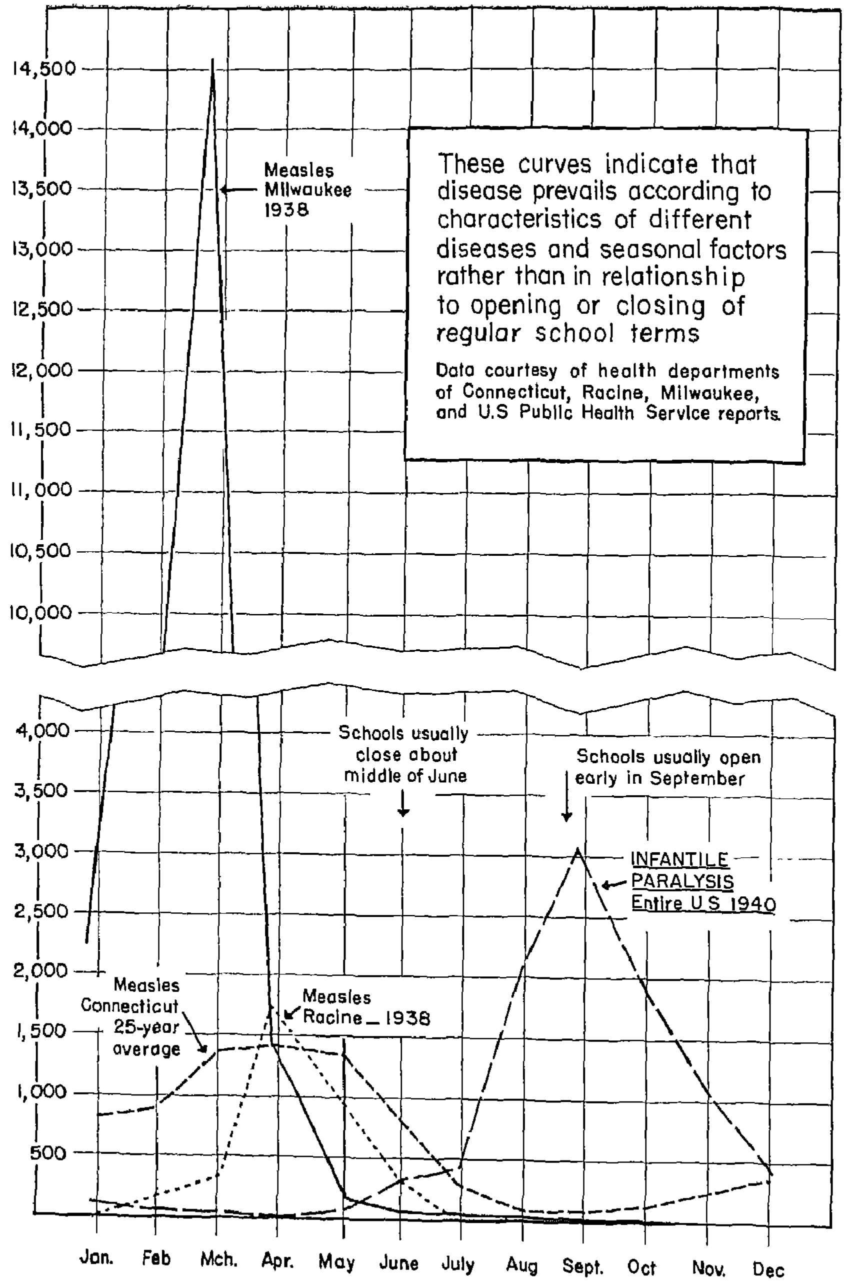


FIGURE X.—RELATIONSHIP OF DISEASE CURVES TO OPENING AND CLOSING OF SCHOOLS

safe as any other place during an epidemic, with the possible exception of the home. Unless the home is administered by exceptionally wise and firm parents, the school may be even safer than the home.

Whenever the schools are reopened after being closed for more than a few days, it is desirable to make a comprehensive inspection of all children on the first day of the newly opened session. This is best done by doctors and nurses, but teachers can do it. Exclusions should be based on the list of suspicious symptoms previously mentioned. Many a minor epidemic of communicable disease or skin infection can be stopped in its incipiency by such a procedure.

Lunchrooms and Cafeterias

Lunchrooms and cafeterias are dealt with in Chapters X and XII. Here they will be considered only as they may affect the transmission of the communicable diseases.

The principal disease groups transmissible thru lunchrooms are the respiratory group and the intestinal group (see Chapter X for classifications).

The respiratory type, transmitted thru the transfer of infection from nose, throat, and mouth, can be minimized as far as the lunchroom or cafeteria are concerned by providing room enough to avoid crowding, encouraging those with colds and related infections to eat by themselves, and excluding from duty food handlers with acute respiratory symptoms while such symptoms remain in evidence. Raw food especially should be protected against handling by such persons. Transmission thru dishes can be prevented by adequate washing. Dishes washed and rinsed in lukewarm water may appear clean but may carry infection. It has been found that dishes must be washed in hot, soapy water and thoroly rinsed in hot water at a temperature not less than 170° Fahrenheit. This applies with especial force to dishes and utensils which may be placed in contact with the mouth, such as glasses, cups, forks, and spoons. Dishes left to dry after a hot rinse are cleaner than those dried on towels; they must be covered against dust while drying. Chemicals in the dish water are needless, if the supply of soap is ample and the water is hot enough.

The intestinal type of disease is spread by swallowing infection. The infection is usually derived from one of four sources: (a) contaminated food, (b) food washed in contaminated water, (c) unclean hands of food handlers, or (d) unclean dishes. The foods most commonly contaminated are milk, meat, sausage, ground meat products, cream-filled bakery goods, and warmed-over foods, especially if they contain cream sauces. The necessary precautions are obvious:

Milk—Use only pasteurized or boiled milk, keep in refrigerator at all times except during actual serving or use.

Meat and meat products—Use good quality products, thoroly cooked; refrigerate except when in actual serving or use; discard left-overs if there is the slightest suspicion of taint.

Cream-filled bakery products—Use only when fresh, especially in summer or hot weather.

Warmed-over foods—Avoid when possible; discard if there is the slightest suspicion of taint.

Examination of food handlers has been advocated as a safeguard to the patron of a public eating place such as a school lunchroom or cafeteria. This statement is true only within limitations, and much money can be wasted by relying too much on this relatively expensive procedure. Food handlers with obvious colds or related symptoms, those who have had digestive upsets, and those with skin infections should not be allowed to work around foods or to wash dishes until they have fully recovered and have been certified by a physician as safe for their occupation. Venereal disease in noncommunicable stages need not preclude employment as a food handler, especially if the individual is under treatment.

Certificates of freedom from communicable disease are of current value only; they give no assurance as to the future. The certificate sometimes issued "good for one year from date" is a delusion and a snare. Even tuberculosis may become manifest and communicable within a few weeks after the best examination. The principal purpose of the health examination is to establish the individual's health status at the time of examination and to afford an educational contact with the food handler.

Training of food handlers in cleanliness of the hands and clothing, scrupulous attention to handwashing before any foods are handled and after every use of the toilet, and establishment of willing cooperation in remaining away from work when suffering with the symptoms previously enumerated are more important than health examinations of food handlers, unless the latter could be done every day. It is reasonable to suggest that a food handler staying away from work for the benefit of others should not be unduly penalized for thus exercising consideration. Arrangements should be made to employ such persons temporarily on other tasks, to allow a reasonable amount of absence without loss of pay when such absences are duly certified by a physician, or to exchange "shifts" with other employees.

Scrupulous cleanliness of the lunchroom or cafeteria plus adequate screening against flies are obvious necessities which should not need to be emphasized. Mice, rats, and pets should be rigidly excluded; often accidental contamination of food with animal droppings, especially those of small rodents which may reach the shelves, is responsible for outbreaks of intestinal diseases.

Food should be stored in containers with secure covers and displayed only during actual serving hours. The best practice is to have glass between the food and the customers. Bread, rolls, and similar items should be handled with forks, forceps, paper napkins, or handkerchief tissues, not with the hands, no matter how clean.

Commercially canned foods have offered no health hazard for a number of years. Home-canned meats and vegetables which are neither acid nor strongly sweetened may become infected, especially with a dangerous organism called *bacillus botulinus*. This is rare but dangerous when it occurs. Contents of cans which bulge or hiss, except vacuum-packed products which always hiss, and canned food products which are frothy or foamy should be discarded and never tasted, for the *botulinus* poison is powerful even in minute amounts.

The suggestions above can be carried out only if the board of education and the school administrator are willing to make the following provisions:

1. Facilities for the cleanliness of food handlers, such as ample locker space, convenient wash basins with hot and cold running water, liquid soap, and towels
2. An ample supply of clean uniforms or aprons of neat appearance
3. Responsible and well-trained supervisors who insist upon thoro routine inspection.

The School Bus

In common with other places where many persons spend an appreciable amount of time in close contact in narrow and perhaps poorly ventilated quarters, the school bus should be included in the consideration of preventive measures against diseases spread by such contact. It is illogical to recommend avoidance of streetcars, stores, and motion pictures and then expect or compel children to use an equally crowded or more crowded school bus. In communities where children are transported long distances to school, the salutary effect of inspections, observations, and exclusions by the teacher, as previously recommended, may be nullified by previous contacts made in the school bus. Apparently the only remedy for this situation is the slow process of teaching parents to keep children at home when they have symptoms of communicable diseases or of colds. Altho communicable diseases are transmitted more by persons than by inanimate objects, the school bus should, nevertheless, be kept in a clean and presentable condition at all times.

Cleaning and Disinfection

The general aspects of cleanliness in the schools are treated in Chapter XII, but certain special emphasis seems desirable here in view of the relationship of cleaning and disinfection to the communicable diseases.

The traditional method of disinfection after communicable diseases is fumigation accompanied usually by the liberation of formaldehyde or sulphur gas into the room or rooms after sealing doors, windows, and crevices. Both these methods are expensive, destructive, unpleasant, inconvenient, sometimes dangerous, and, what is most important, always ineffective. The proper use of fumigation is for the destruction of vermin, not the eradication of germs. Fumigation for contagious diseases was aptly described by Ruhland as "an idle ceremony, an empty gesture, a sacrifice upon the altar of ignorance, and a bad smell."

In the schoolroom, the principal sources of infection are human beings. The presence of communicable diseases does not involve special methods for insuring cleanliness, nor is the use of chemical disinfectants necessary or even desirable. All that is required is a little more thoro application of four simple ingredients of complete cleanliness, namely, soap, water, sunshine, and enthusiasm. Thoro cleanliness is the watchword. Little danger attaches to furniture, walls, and desks, and little more to commonly handled objects such as doorknobs, pencils, pens, and books, unless they are handled almost immediately after being freshly contaminated. Nevertheless, children, parents, teachers, and possibly even school administrators may experience a greater sense of security if desks, window sills, and doorknobs are washed after a communicable disease has been discovered. This means, of course, not all the desks in the room but the ones used by the sufferers.

Disposal of Schoolbooks

The probabilities are that schoolbooks and public library books are unimportant as far as the transmission of disease is concerned. Unless they are grossly contaminated and passed almost immediately to another user, the danger of infection is slight. In view of the numerous cases of unrecognized disease which exist, thru whose hands these books may pass without any precautionary measures becoming possible, it is rather illogical to apply extreme measures to books which are known to have been more or less recently in the hands of persons suffering with communicable diseases. Nevertheless, public opinion changes slowly, and there are demands that something be done. The following simple measures are suggested:

1. Books which have been used by patients with minor communicable diseases such as chicken pox, German measles, and mumps require no special attention unless they have been grossly contaminated, in which case they should be destroyed.
2. Books which have been used by persons with major communicable diseases such as infantile paralysis, meningitis, smallpox, or diphtheria should be put out of use for thirty days and disinfected in a formaldehyde container equipped with racks on which books can be stacked slightly open so that the formaldehyde gas can penetrate between the leaves.

The term "grossly contaminated," as used herein, means obvious contamination with nose or mouth secretions.

If books have been in the home where major communicable disease exists, it should be assumed that they have been used or handled by the patient and they should be treated accordingly. Pamphlets or leaflets used for accessory reading and of small intrinsic value may be destroyed.

Opposition from Obstructionist Groups

Control measures against the communicable diseases, as well as other health measures,[5] may be opposed by community groups actuated by various motives or beliefs. Obviously, the sincerity of an individual's attitudes can be known only to himself. Therefore there is no point in discussing motives beyond saying that the results of certain actions are the same, regardless of whether these actions are prompted by religious belief, devotion to antimedical cults, superstition, ignorance, or prejudice. The results are contrary to the public health and safety of the school children and personnel whenever any person or group persists in:

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[5] See also Chapters III, V, and XV.

1. Failing or refusing to comply with necessary preventive measures
2. Demanding admittance of children to school in violation of established health policies
3. Discrediting and obstructing the school health program by promulgating falsehoods and scare stories about immunizations or the menace to democracy of school health inspections and examinations.

Many groups do these things in various ways. Among the most active are the antivivisectionists, often supported openly or otherwise by the antimedical cults. Their stock procedure is to claim that vaccination does not prevent smallpox, that immunizing preparations of all kinds are "poison," and that school health procedures are a violation of democratic spirit and an encroachment upon the prerogatives of the home. Often this is done by means of letters to local papers from New York or other large cities. The school administrator can readily get the facts about these groups, many of which have deceptively reputable sounding names, by writing to the American Medical Association in Chicago.

This small-group obstructionism is not to be confused with communitywide misunderstandings which may occur. The latter can be overcome, if sometimes slowly, by wise and considerate educational leadership. The professional "anti" wants no education or leadership except the tyranny of his own warped ideas.

Responsibility of School Personnel

Responsibility of school personnel for communicable disease control differs somewhat as do the general administrative functions of principals, teachers, and other school personnel, but as in other matters teamwork rather than differentiation is the important element in success. The principal functions of the different members of the school personnel are outlined separately for emphasis on their principal contributions, but each should regard himself as a member of a coordinated team and should not hesitate to make an appropriate contribution to communicable disease control when the opportunity occurs, even outside his immediate sphere. The school program against communicable diseases depends upon all members of the administrative, instructional, and operating forces of the school system. If any one of these fails, the whole program is jeopardized.

The specific responsibilities of the several groups may be outlined briefly as follows:

1. *The administrative personnel*—Schoolboards, superintendents, assistant superintendents, supervisors, and principals are responsible for the adoption of appropriate policies, their supervision, and the time and facilities necessary for putting them into effect.

2. *Classroom teachers*—Teachers constitute the most important link in the chain of school personnel. By close but informal observation of classes, the teacher is in a position to observe promptly the symptoms or signs which call for exclusion and to refer the child to the school physician, if any, or the school nurse or principal, or, if no doctor, nurse, or principal is at hand, to make the exclusion herself. The teacher is with the class at all times, whereas the physician or nurse can call only occasionally. It is exceedingly illogical to permit a child to remain in a class from the opening of school until near the end of the session when the doctor or nurse may arrive, if such a child arouses suspicion of possible communicable disease. The classroom teacher also has direct control of ventilation, heating, and the amount of outer clothing worn by the children. She can exercise her influence on cleanliness, especially the washing of hands after use of the toilet and before eating. She can link her health instruction with classroom hygiene for more effective teaching and more efficient disease control. She should herself serve as an example of good practice.

3. *The custodian or janitor*—Thru a knowledge of principles of communicable disease control and his supervision over ventilation, heating, cleanliness, and the operation of washrooms and toilet facilities, the custodian or janitor can be of great importance. The schoolhouse janitor should no longer be regarded merely as a performer of menial tasks. He is an important cog in the school machinery. His value should be recognized and he should be taught

his own place in the program and given all the facts and facilities he needs to function at his best.

4. *The school physician*—The physician, if any, should function as a consultant or medical adviser to the administrators in the development and administration of policies pertaining to health. He should be available as a consultant in such matters to the nurses and teachers. He should readmit or supervise the readmission of children excluded for communicable diseases. He should, when necessary, consult with practicing physicians and parents regarding necessary exclusions and other recommendations, especially the promotion of immunization.

5. *The school nurse*—Next to the teacher, the school nurse is the most important factor in the communicable disease control program.[6] Her function is to observe children, make inspections, consult with teachers and principals about exclusions and readmissions, and interpret to the home the reasons for apparently unreasonable exclusions. She should interpret, especially to new teachers, the principles and practices involved in protecting the school against communicable disease by a policy of exclusion upon suspicion without waiting for diagnosis. She should exercise her influence to promote immunization against communicable diseases wherever practicable. She should assist the school physician in his contacts not only with the home but with the practicing physicians in the community.

6. *The parent*—Altho not under direct control of the school system, the parent is the most important factor in the whole situation. If it is good practice to protect the school against communicable diseases by early exclusion, it is obviously better practice to keep the sick child at home than to send him to school only to be excluded. By the time he has reached school he has made many contacts even if he is excluded at once by an alert teacher. A child makes the fewest contacts with other children, including those in his own home, if he is kept in his room away from other children until suspicious signs previously enumerated either clear up or are definitely identified.

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[6] National Education Association and American Medical Association, Joint Committee on Health Problems in Education *The Nurse in the School.* Washington, D C · the National Education Association, 1941. 40 p

Shall Schools or Health Departments Administer?

Among the lively discussions now current is the one whether school health work shall be supervised by boards of education or by boards of health. The underlying principles are dealt with more fully in Chapter XV. The specific points in connection with communicable disease control are the following:

1. Responsibility for the administration of quarantine and other control measures is vested by law in the board of health Communicable diseases must be reported to the board of health by school authorities if the school health program is not administered by the board.
2. Home supervision of communicable diseases is necessarily carried out by the board of health; therefore, close cooperation must be established by school authorities with the board of health to coordinate home and school procedures.
3. If public schools administer their own communicable disease measures, and private and parochial schools are served in similar capacity by the board of health, the programs must be consistent and well coordinated to avoid community confusion, lack of cooperation, and resentments based upon real or fancied discriminations.
4. If the communicable disease program is administered by the board of health, it must be carefully coordinated with school schedules and the operations of school plants, and there must be opportunities for teacher instruction by the health department.

Like many administrative problems, this one seems to resolve itself finally into a question of human relationships. There can be (and is) good cooperation between school personnel and health department personnel, or there can be (and is) lack of cooperation. There can be (and is) good cooperation between various departments in a school system, or there can be (and is) friction and failure. In either case the fault probably lies not in the system but in the spirit of its personnel.

CHAPTER X

Communicable Disease: Types and Specific Controls

THE COMMUNICABLE DISEASES OF CHILDHOOD are commonly classified according to their *principal* mode of transmission, as follows:

1. The respiratory group, transmitted principally by the secretions of the nose and throat, but occasionally subject to transmission by other means. A typical example is diphtheria, which is usually a respiratory disease but may occasionally be transmitted by infected milk and may also infect wounds.
2. The skin contact, or mucous membrane contact group, which is usually acquired thru broken places in the skin or mucous membrane.
3. The gastrointestinal group, transmitted as a rule by swallowed infection.
4. The insect-borne group transmitted by the bites of various insects.

It is important to note that this classification represents a mode of transmission and not a clinical classification of the disease. For example, a respiratory disease such as diphtheria involves the entire body. So does a skin contact disease such as lockjaw, or a gastrointestinal type such as typhoid fever, or an insect-borne disease such as malaria. The clinical course of disease is not of interest to the schools except as it may influence the manner of transmission and, therefore, these diseases are classified by their *ordinary* mode of transmission. (See summary of diseases, pages 202-203.)

This chapter presents the principal communicable diseases of childhood, together with an outline of the general principles of control for each and suggestions as to the part which may be played by the school.

Respiratory Types of Disease

The Common Cold

The key disease common to children and adults on which all programs for communicable disease control must be based is the common cold. This is because the cold itself is a communicable disease and, even more important, "what seems to be the ordinary cold may be the onset of measles, whooping cough, or another communicable disease, so that every cold should be regarded as the possible beginning of a communicable disease. The failure to control communicable diseases in the school has been due in large part to the policy of not excluding children with acute colds."[1]

The person with the common cold feels ill; his nose suffers either from running or stuffiness, or both. His eyes may be inflamed and sensitive to light. He may have a cough, sore throat, or fever. Complications may involve the sinuses of the head, the ears, and the lungs. The common cold is transmissible by means of the secretions of the nose and throat. All these symptoms and this mode of transmission may be found in a large group of communicable diseases, classified according to the mode of transmission as respiratory communicable diseases. Many of these diseases in their incipiency may be mistaken for the common cold. For all these reasons, control of the common cold is fundamental in any program of communicable disease control in the school.

In addition to its transmissibility, the common cold is influenced by other factors, chiefly fatigue, overcrowding, exposure, poor ventilation, overheating indoors, overdressing indoors, underdressing outdoors, overeating, or poor nutrition. Many of our young children suffer from a great drain on their physical vitality when styles require that legs and thighs be completely exposed. To all these factors the school can devote attention. Except for undernutrition and overeating, most of these factors are definitely controllable as long as the child is in school, and the school can exert its educational influence and leadership toward better practices in the home.

Under practical conditions the cold can seldom be eliminated from the school entirely, but some measure of control can be exercised thru the following procedures:

1. Discouraging the presence in the school of children and teachers with any of the suspicious symptoms enumerated in Chapter IX.
2. Educating parents and encouraging them to observe children closely before sending them to school and keeping them home when there are evidences of the common cold.
3. Constant and intelligent control of ventilation and heating.
4. Requiring when indoors the removal of outer wraps, heavy clothes, sweaters, mufflers, galoshes, and rubbers.
5. Discouraging by precept and practice the borrowing of pencils, pens, and similar objects which may have been in some other child's mouth or hands.

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[1] Chenoweth, Laurence B., and Selkirk, Theodore K. *School Health Problems.* New York, F. S. Crofts and Co., 1940 p 102

6. Discouraging by precept and practice the putting of any objects other than food into the mouth.

7 Encouragement of the hygienic use of the handkerchief or handkerchief tissues

8. Abandonment of false emphasis on "perfect" attendance. The special pleading that to send all teachers and pupils home who have colds is to deplete and disorganize the school and classes is false. If each child and teacher were sent home at once they would not infect the others and there would be fewer colds.

Smallpox

One of the most readily transmitted of the serious communicable diseases of the respiratory group is smallpox. It begins like an attack of so-called grippe and the eruption does not appear for several days. "The prevention of smallpox depends upon vaccination. Vaccination was the first specific prophylactic measure given to man; it produces an active immunity to smallpox. Despite its importance and great practical value, there is much anti-vaccination sentiment due to ignorance or misconstruction of the facts." [2]

The occurrence of smallpox in the school should be forestalled by a communitywide program of smallpox vaccination by which parents are encouraged to have babies vaccinated in the first year, again before entering elementary school, and again before entering high school. Vaccination should be encouraged, and under some state laws may be required regardless of previous vaccinations, whenever a case of smallpox appears in the school district. Vaccination of all teachers is recommended. Practical enforcement of such laws dictates exemption from revaccination of all who can present evidence of successful vaccination within the previous five years.

Altho compulsion is theoretically undesirable except as a last recourse, the requirement of vaccination for admission to school has worked well in some communities, where intelligent administration of the law or regulation emphasized leadership rather than coercion and avoided needless and often disastrous controversies with conscientious objectors. The principle underlying compulsion is the safety of the community. Vaccination should apply to teachers and janitors as well as to students.

In connection with smallpox it is important not to confuse it with a similar disease, chicken pox. The latter is of small importance in itself and at the high-school age and beyond it is rare, but steps should be taken routinely to make certain that so-called chicken pox is not actually smallpox.

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[2] Rosenau, Milton J *Preventive Medicine and Hygiene.* New York· D Appleton-Century Co, 1935 p 2-3

Diphtheria

Once a serious menace, diphtheria is now less dangerous because of immunization against the disease as well as the comparative ease of accurate diagnosis and the availability of highly effective curative treatment. Mortality is still higher than necessary; many cases are not identified because no one looks for it. It may be passed over as tonsillitis, this confusion causing a late diagnosis when *early* curative treatment is so important. Therefore, wisdom dictates prevention rather than awaiting the necessity for cure. "In the case of diphtheria we have a test for immunity that is lacking for most other diseases."[3] Prevention is accomplished by injection of a preparation known as toxoid. The details of the procedure are of medical interest and need not be set forth here. Children should be protected in the first year of life, but those who enter kindergarten or higher grades unprotected had better be protected late than not at all.

The difference between protecting the community against epidemics and rendering every child safe from diphtheria has been demonstrated by Godfrey[4] who showed that immunization of 35 percent or more of preschool children will effectively protect a community against epidemic outbreaks, while immunization of much larger proportions of school children has no such effect. His studies emphasize two points, namely, the importance of encouraging immunization *in the preschool years* and the fact that unimmunized children are still in danger of diphtheria even tho the community may be safe from epidemics.

When a case of diphtheria appears in a schoolroom the child must be excluded in accordance with local regulations and nose and throat cultures made from other children with whom there has been contact. Arbitrarily taking cultures from all persons in a schoolroom and ignoring other possible contacts is not good procedure. It is quite possible that a child in a remote seat in the same room may have been less exposed than a child from another room whose contact may have been in washroom, playground, corridor, or elsewhere.

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[3] Chenoweth, Laurence B., and Selkirk, Theodore K., *op. cit.*, p. 170

[4] Godfrey, Edward S. "Study in the Epidemiology of Diphtheria in Relation to the Active Immunization of Certain Age Groups." *American Journal of Public Health* 22: 237-56; March 1932.
‖ Godfrey, Edward S. "Practical Uses of Diphtheria Immunization Records." *American Journal of Public Health* 23: 809-12. August 1933.

Scarlet Fever

Scarlet fever is one of the more serious diseases, largely because it appears in many forms varying from mild to severe. Mild cases can transmit severe infections to others. It is characterized at the onset by sore throat, fever, stomach upsets, and a red rash appearing about twenty-four hours after the earliest symptoms. According to findings of the Sub-Committee on Administrative Practice in Control of Scarlet Fever of the American Public Health Association, scarlet fever may be present without the rash. Protection of the schools is by exclusion until all the symptoms have disappeared. Various state laws set minimum quarantine limits at twenty-one days, twenty-eight days, and thirty-five days, but cases should be quarantined as long as symptoms, or positive throat cultures, persist. The disease is often spread by children who have had light attacks but who suffer complications such as discharging ears, sores about the nose and mouth, draining glands, and infectious discharges from the nose and throat.

Immunization is available but is best left to the judgment of the family physician since it is by no means as easy, reaction-free, or effective as smallpox and diphtheria immunization and there is effective curative treatment for cases severe enough to require it. Modern drugs probably shorten its course and prevent many complications, thus making immunization even less to be considered.

Bacterial cultures from the nose, throat, or from any abnormal discharge are often utilized in determining return to school after scarlet fever; the criterion is the absence of the *hemolytic streptococcus* from the culture. Similar cultures to identify carriers have also been tried with varying success. One excellent way of picking up potential cases among exposed children is by taking the temperature daily for two or three days after exposure. Children with fever are excluded. Some of them prove to have had only a fleeting temperature elevation, but enough of them develop scarlet fever to justify the procedure which can readily be carried out by the school nurse and even by the teacher with appropriate and not too expensive equipment.

Streptococcus Sore Throat

A serious type of throat infection is streptococcus sore throat, due to one of the germs of the streptococcus family. It is often closely related to scarlet fever and to acute rheumatic fever. It is spread principally thru raw milk but is also transmitted from person to person. Schools should use pasteurized milk only and should promptly exclude children with sore throats.

Measles

"Measles is a typical contagious disease because it is one of the most readily communicable of all infections, in this regard ranking with smallpox and pandemic influenza. As a cause of death it rates high among the acute fevers of children." [5]

It occurs in periodic waves beginning from twenty-four to thirty months apart, most commonly in spring or fall. Fall epidemics may persist thru the winter and far into the spring but spring epidemics usually subside with warm weather. The rise and fall of the curve of the prevalence of measles are often independent of the opening or closing of school, hence it cannot justly be said that school attendance is primarily responsible for the epidemic (see Figure X). This phase of the question is discussed more in detail under the heading of "Closing School for Epidemics," Chapter IX.

Measles is a disease exceedingly difficult to control because of its highly communicable character. The symptoms begin with sneezing, coughing, sniffling, watery eyes and nose, a general feeling of illness, and other common cold symptoms. Usually from one to three days elapse between the initial fever of invasion and the appearance of the eruption. The usual practice is to exclude children who have it for from seven days to two weeks, according to different state board of health rulings. Exposed children who have had the disease are generally permitted to remain in school where supervision is provided. Children who have not had the disease are excluded for two weeks, or for the last five days of the fourteen immediately following exposure. The disease is not in a communicable stage during the earlier part of this so-called incubation period. These exclusions are based upon the fact that a second attack of measles is rare tho not unknown and there is usually a lapse of from seven days to two weeks between exposure and symptoms of the disease. Special means for preventing measles by immunization are not of such widespread applicability that they need enter into the consideration of school authorities.

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[5] Rosenau, Milton J., *op cit*, p. 75.

Infantile Paralysis

Poliomyelitis is a relatively rare but much dreaded disease because it may seriously impair the effectiveness of those who reach the paralytic stage but do not succumb. The key to prevention is the fact that the paralytic cases represent only the advanced stage of the disease; there are many mild cases with indefinite, vague symptoms of fever and illness but no paralysis. The disease is characteristically a late summer and early autumn disease. Because of this fact, opening of the schools is sometimes delayed when there is an epidemic. This procedure is also discussed in more detail in connection with closing the schools in the presence of epidemics. The only protection the school has against infantile paralysis is the exclusion of sick children or of those with indefinite symptoms not readily identifiable as noncommunicable.

Meningitis

There are several types of meningitis, of which the most important is epidemic cerebrospinal meningitis, sometimes known as cerebrospinal fever. The disease is rare but serious. It is a generalized infection centralizing in the brain and nervous system. Its early symptoms are deceptive and confusing. It is spread by air-borne infection, as are the ordinary contagious diseases of childhood. The schools have no specific protection against it except the exclusion of sick children and of contact carriers identified by nose and throat cultures.

Epidemic Encephalitis

Sometimes known as sleeping sickness, this is a disease which has been observed only recently. Its method of transmission is not clear, altho suspicion has been directed against some sort of an insect carrier because the disease tends to disappear with cold weather, when insects also disappear. In case of an outbreak of encephalitis, current advice issued by state boards of health and the United States Public Health Service should be followed. The status of available information is too uncertain to permit a definite statement at this point.

Rheumatic Fever

This fever and its complication, chorea or St. Vitus' dance, are streptococcus infections due to variants of the same organisms which produce scarlet fever and septic sore throat. It is, therefore, more common among school children than is generally realized. It is frequently the cause of injury to the heart. When infection attacks the brain, nervous symptoms may result, giving the characteristic picture of restlessness or twitching called St. Vitus' dance or chorea. The disease itself is not transmissible, but infections which may give rise to it are transmissible thru contact by which nose and throat secretions may be "exchanged." The precaution against it is the exclusion of sick children.

Whooping Cough

Another disease which occurs in periodic waves from twenty to thirty months apart is whooping cough. It is commonly more prevalent than other children's contagious diseases during the summer, but there are many exceptions; it commonly reaches its peak in the spring. It begins with a cough which might be due to a cold but which persists, finally developing a spasmodic character, usually with whooping but sometimes without. The disease is now being attacked somewhat experimentally with communitywide immunization of babies. As far as the schools are concerned, the only protection they have against whooping cough is the exclusion of all children with coughs. Excluded cases should remain away long enough for practical protection. "The attitude of indifference with which the general public regards whooping cough contrasts strangely with the fact that it is one of the most distressing and fatal of the acute infections of childhood." [6]

Mumps

This is a highly contagious condition transmitted thru the secretions of the nose and throat. In little children, aside from the pain and discomfort of the swollen salivary glands, it is of little consequence, but at the secondary-school level where most of the pupils have passed puberty it must be regarded as potentially a major disease, owing to its tendency to involve the sex glands, with possible resulting sterility. Fortunately, most children have mumps before puberty. From the standpoint of the schools there is little to be done except to exclude children with signs of illness, especially swellings about the face or unexplained fever. Parents should be encouraged during an epidemic of mumps to watch for suspicious signs and to keep such children at home.

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[6] Rosenau, Milton J., *op. cit.*, p. 96.

Chicken Pox

Chicken pox is important largely because of the absences which it occasions. It is usually a mild disease tho not entirely free from serious complications. Children are not often very ill or seriously incapacitated but their appearance is not engaging. They require treatment to control itching which may stimulate scratching and result in the development of unsightly scars which could otherwise have been prevented. The usual practice is to keep children at home until the chicken pox rash has healed. Exposed children need not be subjected to any special supervision. Among older children and adults it is important to be sure that supposed cases of chicken pox are not actually smallpox. Vaccination against smallpox has no effect on chicken pox.

German Measles

A disease similar to measles is German measles, but it is milder and of less consequence. Care should be taken that the more serious scarlet fever is not mistakenly diagnosed as German measles. The disease rarely has any serious complications except in weakened or sickly children; normal children usually are not very ill. The customary procedure is to exclude cases from school until the symptoms and physical evidences have disappeared. Exposed children require no special supervision.

Tuberculosis

This is a communicable disease that can be transmitted from person to person in the classroom as elsewhere. The principal danger comes, however, from the adults in the school rather than from the young children. A safe policy should require satisfactory evidence that every adult employee of the school, whether or not he comes in contact with children, is free from tuberculosis in a communicable stage. This is of particular importance as it relates to teachers because of their close and prolonged contacts with children.

The discovery of tuberculosis no longer depends on the observation of symptoms. It is true that the tuberculous person first manifests quick fatiguability, loss of weight, digestive disturbances, persistent cough, and slight fever, but even these symptoms, once designated as early signs, are now known to appear only when the disease has already made considerable progress. Recognition of tuberculosis in the modern manner depends upon more precise methods, namely, the tuberculin test and the X-ray.

Tuberculin testing of adults and of children at the secondary-school level is now recommended as a universal practice. At the primary level tuberculin testing is recommended for children known or suspected of having had contact with tuberculous persons. There are four ways in which the tuberculin test has been given. The choice of technic is a medical problem, but there are certain administrative features connected with the various forms of tests. All forms of tuberculin testing are performed with preparations known as tuberculin, made by various processes from the bodies of killed *tubercle bacilli*. An individual cannot be infected with tuberculosis by any form of tuberculin testing. The use of tuberculin in the treatment of tuberculosis is not here under discussion except to point out that it is a totally different matter from tuberculin testing.

The tuberculin test is a test of sensitivity. It elicits a reaction from tissues sensitized to tuberculin by previous infection with tuberculosis somewhere in that individual's body. The test is no indication as to the activity of the disease. It merely proves, when positive, that the patient has been infected once. Whether or not the infection resulted in active disease and whether or not the disease remains at the time of tuberculin testing are matters for further investigation.

The four forms of tuberculin testing are as follows:

1. The Morro Test, performed with a tuberculin ointment. This test is now practically obsolete.

2 The von Pirquet Test, made by scarifying, or scratching, the skin and applying tuberculin in much the same manner as smallpox vaccination is sometimes performed.

3. The Mantoux Test performed by injecting a measured amount of tuberculin preparation between the layers of the skin The Mantoux Test has the advantage over other tests in that it employs an accurately measured dosage and places it in a circumscribed area where it can readily be inspected. Its disadvantages are that it requires the use of a needle, which may alarm some patients, and that in children and persons with very delicate skin it is difficult to perform. As with all precise tests the accuracy of technic greatly affects the accuracy of the test. If injections are made under the skin instead of into the skin the result is a false negative.

4. The Patch Test is a newer development tho it is a refinement of the Morro Test, previously described. Instead of merely applying the ointment to the skin, the ointment is applied on a strip of gauze which is held in contact with the skin by an adhesive plaster circle which excludes air from the area of skin under testing and holds the tuberculin ointment in close and prolonged contact with the skin.

The Mantoux Test is the most accurate and reliable and should be used in every instance except where strong objections are made to the use of a needle or where other factors may make it necessary to employ a Patch Test. The proportion of errors in the Patch Tests varies between 10 and 15 percent, while in Mantoux Tests properly performed and skilfully interpreted one should expect no more than 1 or 2 percent error.

When tuberculin testing has been done, all those with positive tests should be further examined and should have X-ray plates of the chest. Only a small percent of those with positive tests will prove to have tuberculosis in active form. The determination as to whether a person with tuberculosis is a menace to others depends neither upon the tuberculin test nor upon the X-ray but upon the discovery of *tubercle bacilli* in the secretions. This may be done by examining sputum specimens but not less than thirty negative reports should be accepted as assurance of safety because the discharge of organisms may be intermittent or there may be so few that they are not readily detected by any practicable laboratory procedure. A new test which has been employed with great success, where practical, is the examination of stomach washings instead of sputum. Whether or not the tuberculous individual, whether he be teacher or pupil, is a menace to others he should, of course, be out of school and under treatment as long as he is ill.

Tuberculosis is really a double infection; that is, in all but rare instances, two infections are necessary—a primary type from which recovery is the rule, and a secondary infection from which recovery may or may not occur. Most primary infections occur in childhood, and have therefore been erroneously referred to as "childhood type"; most secondary infections occur in adults and have consequently been referred to with equal lack of accuracy as "adult type" tuberculosis. This inaccuracy does no harm if it is remembered that either type may be found in either child or adult.

Vincent's Infection

A type of sore throat which may be confused with tonsillitis, diphtheria, or scarlet fever is due to Vincent's infection, sometimes called Vincent's angina. The infection gets its name from the fact that it is due to two organisms found constantly in association and so described by Vincent. These are a bacillus and a spirillum. The disease manifests itself by a sore throat, ulcerative in character, tending to be both severe and prolonged in some instances. It may also affect gums and cheeks. Identification is usually made by laboratory examination of direct smears from the ulcerated region, plus cultures to rule out the possibility of diphtheria or streptococcus infections. Children with Vincent's infection should be excluded from school. The disease is spread by contact, by eating utensils, and by handling of toys and other objects which may have been recently contaminated. Treatment is often prolonged and sometimes unsatisfactory, and there may be considerable loss of school time. Exposed children usually need not be restricted unless health authorities find special circumstances requiring such restriction.

Diseases Entering the Body thru Skin Contacts

Rabies

Whenever a child is bitten by a dog, rabies (hydrophobia) must be taken into consideration. Most dog bites are due to playfulness, accident, viciousness, or teasing, but one can never be sure unless proper precautions are taken. The bitten child, or a child who has been playing with a dog believed to be rabid, whether or not bitten, should be seen at once by a physician. Infection may occur thru cuts or abrasions if licked by a rabid dog. Special attention should be paid to bites on the face or other areas not protected by clothing.

The dog should not be shot, but should be locked up for ten days. If the dog dies, the head should be sent to a clinical laboratory for examination. If it is necessary to shoot the dog in self-defense or other emergency, efforts should be made to avoid shooting him in the head. If the dog lives for ten days, there need be no fear of rabies. If he dies in the interim, a physician should decide whether or not Pasteur treatment for the prevention of rabies should be administered to persons bitten.

TABLE 2.—SUMMARY OF COMMUNICABLE DISEASE CHARACTERISTICS

Disease	Incubation [a] (days)	Usual mode of transmission	Period of greatest communicability	Immunization	General control measures	Usual length of quarantine or isolation [b]
Colds	*1*–2	Nose and throat secretions	First three days	None	Avoid exposure	None, except self-imposed
Smallpox	9–*12*–15	Nose and throat secretions	From pre-eruptive stage until recovery	Vaccination	Quarantine cases and contacts [c]	14–21 days; contacts 14 days unless successfully vaccinated
Diphtheria	*2–7*	Nose and throat secretions	While throat and nose cultures are positive	Toxoid	Quarantine cases and contacts [c]	Until 2 (or 3) negative cultures, same for contacts and carriers [d]
Scarlet fever	2–*3*–7	Nose and throat secretions	As long as any abnormal discharge persists	Dick toxin	Quarantine cases and contacts [c]	Variable minimums from 21–35 days, but usually until abnormal discharges cease, contacts excluded for 7 days
Measles	11–*12*–14	Nose and throat secretions	During pre-eruptive stage, declining after rash appears	Convalescent serum or placental extract	Isolate cases and contacts who have not had measles	Up to 14 days for cases, contacts excluded unless they have had it
Poliomyelitis	10–*14*–18	Nose and throat secretions; also possible intestinal discharges	Preparalytic stage	None	Quarantine cases	Arbitrary; usually at least 2 weeks
Meningitis	Unknown	Nose and throat secretions	While meningococci persist in nose and throat	None	Quarantine cases	Until 2 post-nasal cultures are negative, same for carriers [d]
Encephalitis	Uncertain	Uncertain, possibly insect borne	Unknown	None	Quarantine cases	No established practice
Whooping cough	4–*10*–17	Nose and throat secretions	Before the whoop develops	Vaccination in infancy	Isolate cases and contacts	Four weeks, if 2 negative cough plates are obtained
German measles	14–*17*–21	Nose and throat secretions	Pre-eruptive stage	None	Isolate cases	7–14 days isolation
Mumps	*18–20*–21	Nose and throat secretions	Before symptoms appear and up to 6 weeks after	None	Isolate cases	Isolation of patient only
Chicken pox	14–*17*–21	Nose and throat secretions	Before eruption appears	None	Isolate cases	Isolation of patient only
Tuberculosis	Months or years	Nose and throat secretions; milk, food	Whenever sputum contains tubercle bacilli	None	Isolate cases with positive sputum, keep contacts under observation	Usually not compulsory, unless gross negligence is shown or children are exposed

Rabies	14–*40*–365+	Wound infection	Spread by animal bites only	Pasteur vaccine	Confine and observe rabid or suspected animal, leash dogs	None for human patient, animal held for confirmation of diagnosis
Tetanus	6–15	Wound infection	Seldom communicated person to person	Toxoid antitoxin	Prompt attention to wounds	None
Septic infections	Variable	Wound infection	Seldom communicated person to person	None	*Prompt attention to* wounds	None
Syphilis	14–21	Broken skin or intact mucous membrane	Whenever open sores exist on skin or mucous membrane	None	Require treatment of all cases until noncontagious	Usually not compulsory unless gross negligence is shown
Gonorrhea	14–21	Broken skin or intact mucous membrane	While gonococci exist on skin or mucous membrane	None	Require treatment of all cases until noncontagious	Usually not compulsory unless gross negligence is shown
Barber's itch	3–7	Broken skin	Any time	None	Exclude from school unless under treatment with appropriate dressings	None
Impetigo	3–7	Broken skin	Any time	None	Exclude from school unless under treatment with appropriate dressings	None
Ringworm	3–7	Skin, unbroken	Any time	None	Exclude from school unless under treatment with appropriate dressings	None
Scabies	2–3	Skin, unbroken	Any time	None	Exclude *until complete* recovery	None
Pink eye	3–5	Eye, via hands or towels	Any time	None	Exclude until complete recovery	None
Typhoid	7–*10*–*14*–23	Water, milk, or food contamination	As long as typhoid bacilli are discharged	Vaccination	Exclude until no longer a carrier [d]	None; precautions taken in disposal of stools and urine
Food poisonings	−1–*1*–2	Food contamination	Any time	None	Clean food handling practices	None
Undulant fever	*14*–variable	Milk	Any time	None	Pasteurize milk	None

[a] Time elapsed between exposure and the appearance of symptoms, shown thus: *minimum–usual*–maximum.
[b] "Quarantine" refers to patient and family; "isolation" involves patient only
[c] Contacts are exposed persons.
[d] Carriers are persons infected but not *ill*

Tetanus

Whenever a child sustains a deep-punctured injury from which little bleeding results, or a bruised, torn, and battered wound contaminated with street dust or playground or athletic field soil, tetanus or lockjaw must be considered. Injuries from shiny implements are just as dangerous as those from rusty ones, other factors being the same. Tetanus is easily prevented by the administration of an antitoxin in adequate dosage. Immunization may be carried out by a toxoid and is now sometimes combined with toxoid used for diphtheria immunization.

Hookworm

In certain southern rural areas an important problem is hookworm infestation. The life cycle of the hookworm need not be discussed in detail here. It should be pointed out, however, that the eggs are discharged by the infected person thru the bowels and when the larvae are picked up from the ground by persons walking barefoot, they cause what is commonly called "ground-itch." From the point of entry on the feet these larvae find their way thru circulatory channels to the lungs and eventually to the stomach and thus start life over again. The important knowledge for the school administrator is that this cycle of transmission can be broken most effectively, with the cooperation of physicians and health authorities, in four principal ways, which are as follows:

1. Detection and treatment of all persons infected with hookworm
2. The construction of sanitary toilet facilities and insistence upon their use
3. The wearing of shoes whenever possible
4. Thoro training of children and thru them of their parents in the use of sanitary toilet facilities in preference to indiscriminate and wholesale soil pollution.

Ringworm Infections

Infections with a trichophyton fungus, technically known as *trichophytosis,* popularly as ringworm, and commercially as "athlete's foot," are common problems in school. With the growth of physical education and athletic participation and the increase in the number of gymnasiums and their use, the most common form of ringworm infection today is not the same as was experienced in the schools a decade or so ago. In earlier days ringworm infections in the schools involved usually the face or the scalp and sometimes the borders of the nails, and except in the latter case were usually relatively easy to treat successfully. Now the principal problem is ringworm infection of the feet, which is commonly attributed to athletics and physical education facilities. It is true that these facilities when not properly operated do tend to favor ringworm infection of the feet, but they are by no means the only source. The fungus is widespread, is hard to kill, and may be picked up by walking barefoot anywhere, even in one's own bedroom.

From the administrative standpoint the prevention of ringworm involves problems of construction and operation of the school plant, which are being taken up elsewhere. Assuming that the plant has been properly constructed or that satisfactory improvised methods can be arranged, the important points in the prevention of ringworm are as follows:

1. Scrupulous cleanliness of floors in gymnasiums, locker rooms, shower rooms, and floors surrounding pools and other athletic facilities. Particular attention should be paid to the cleanliness of mats used in gymnastic or wrestling exhibitions.
2. Scrupulous cleanliness of towels or swimming suits when used on a rental basis
3. Insistence upon complete bathing of the body and washing of the feet before using athletic facilities.
4. Scrupulous cleanliness of the feet.
5. Requiring all users of athletic facilities to provide their own footwear and wear it at all times; this involves the use of sandals or slippers which can be worn into the showers.
6. Requiring all bathers or users of showers to walk thru a solution of 5 percent sodium thiosulphate, ordinarily known as photographers' hypo, or 1 percent sodium hypochlorite.[7]

The precautions listed above are not given in the order of their importance, since all are equally essential. Even with the exercise of all precautions, there will still be a certain amount of ringworm infection of the feet acquired from sources other than athletic facilities. Altho the infection is not particularly difficult to treat in simple cases, reinfection readily occurs owing to the wide distribution of the fungus.

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[7] Osborne, Earl D., and Hitchcock, Blanche S. "The Prophylaxis of Ringworm of the Feet." *Journal of the American Medical Association* 97: 453-55, August 15, 1931 Free when requested on school letterhead.

Septic Infections

Whenever there is an injury which breaks the skin, septic infections or local tissue infections may occur. First aid should be rendered promptly and effectively. Teachers and children should be encouraged to report such injuries. The details of first-aid instruction can be found in such manuals as the Red Cross *First Aid Text-Book*[8] and *Everyday First Aid*.[9] (See also the discussion in Chapter XI of this yearbook.)

Venereal Diseases

Except possibly in the secondary schools, venereal diseases are not usually thought of in connection with school health programs. It should be remembered that these diseases are communicable thru nonsexual contacts. Gonorrheal vaginitis in little girls may easily become epidemic, and destructive eye infections may result. Rarely children may accidentally become infected with syphilis in the home and still more rarely may secondarily infect others in the school. These diseases are difficult to detect and their handling requires not only epidemiological skill but sociological finesse. In addition to vigilance of nurses, teachers, and school physicians, general precautions include the standard hygienic procedures such as washing of the hands after use of the toilet, the avoidance of common eating or drinking utensils, and the use of individual paper towels, plus the exclusion of all children with skin rashes or inflammations in the mouth and throat, unless the cause has been determined.

Skin Diseases

Almost limitless in their possibilities are skin diseases or eruptions which may occur in school. Some of them, such as hives, eczema, and other noncommunicable diseases, are of no concern to others except that they may be objectionable in appearance or may create problems involved in dressings. Some skin eruptions may be early signs of communicable diseases, especially measles, scarlet fever, German measles, or chicken pox. Still others include the communicable skin diseases themselves of which the most common are barber's itch, impetigo, ringworm, and itch. Owing to the inability of teachers or nurses to distinguish the communicable from the

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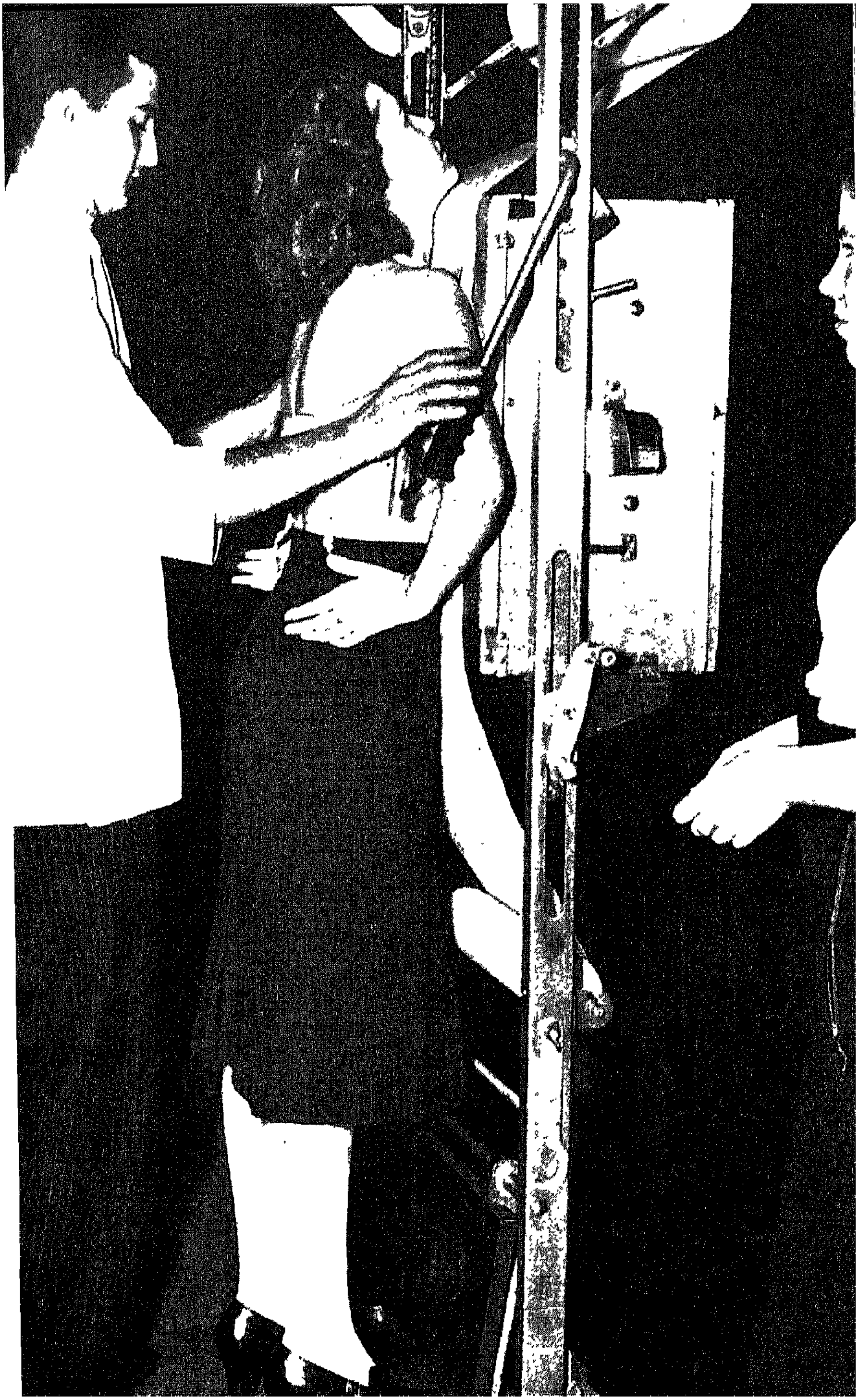
[8] American National Red Cross. *First Aid Text-Book.* Philadelphia: P Blakiston's Son and Co, 1937 256 p.

[9] Cobb, Walter F *Everyday First Aid* New York: D. Appleton-Century Co., 1937. 269 p.



EXAMINATIONS IN SECONDARY SCHOOL—*In the adolescent years physical examinations, particularly by means of the fluoroscope and X-ray, are of special importance. These devices often detect tuberculosis in its early stages. The adolescent even more than the elementary-school child may be expected to improve and conserve his physical endowment.*

Photograph by
U. S. Public Health Service

noncommunicable, the safest procedure is to exclude all children with conditions of this kind until they have been medically certified. With respect to the communicable skin diseases the usual procedures are as follows:

1. *Barber's itch*—Exclude unless under medical treatment and appropriately dressed to prevent spreading and to be unobjectionable.
2. *Impetigo*—Exclude unless under medical treatment and appropriately dressed to prevent spreading and to be unobjectionable.
3. *Ringworm*—Exclude unless under medical treatment and appropriately dressed to prevent spreading and to be unobjectionable
4. *Itch*—Rigid exclusion until complete recovery, certified by physician or nurse.

Lice

The most irreproachable family may be invaded by lice of the body and head. Children infested with head lice or body lice should be excluded from school until inspection by the school nurse discloses that their readmission is safe.

Pink Eye

The most contagious of the eye inflammations which may affect children is pink eye. It is due to a specific organism which can readily be identified. It is spread by contact, thru fingers, towels, and any object which may come in contact with the eye. Children with inflamed eyes should be excluded until there has been a satisfactory demonstration that no contagious condition exists.

Diseases Entering the Body thru the Digestive System

Typhoid Fever

The typical disease which can be acquired by swallowing is typhoid fever. The germs are eliminated from the bodies of those who have typhoid fever thru the intestinal discharges and sometimes the urine, and may reach the bodies of subsequent victims thru contaminated water or milk, food eaten raw, or infected fingers of persons with unclean personal habits. Flies also may transmit this disease by contaminating food. Related diseases are the paratyphoid fevers (see "Food Poisonings" section), dysentery, cholera, and the intestinal disease or cholera morbus of infants. As far as the school is concerned, control of these diseases consists in insistence upon a safe water supply, the use of pasteurized milk only, exclusion from school of sick children, selection of healthy persons only for duty as food handlers, and plenty of facilities for cleanliness of the hands after use of the toilet and before eating.

Food Poisonings

As in any other restaurant or in the home, food poisonings may occur in school cafeterias or lunchrooms. The principal ones are those coming from contaminated meat and from other contaminated foods eaten raw or from foods which have been infected after preparation. Certain foods, especially cream fillings for cakes and pastries, are particularly susceptible when contaminated with germs of the food poisoning group. These germs multiply and produce toxins or poisons in such rich culture media, and may give rise to acute and sometimes serious symptoms of the kind popularly but inaccurately known as ptomaine poisoning. Foods of this class stored in uncovered containers are sometimes contaminated by mouse droppings, with similar results. Protection against these forms of infection consists of the following measures:

1. The use of fresh, unspoiled, inspected meat and thoro cooking of the same.
2. Careful washing with water of known purity of all foods eaten raw, particularly salad vegetables.
3. Scrupulous cleanliness of the hands, and especially the nails, of food handlers; exclusion from food handling service of persons with infected cuts or sores on the hands and of typhoid or dysentery carriers.
4. Destruction or pasteurization of all cream-filled pastries and cakes not eaten the same day they are prepared, especially in hot weather.
5 Storage of food only in covered containers which assure safety from accidental contamination.

Poisonings from commercially canned foods are extremely rare today.

Undulant Fever

This is a disease related bacteriologically to so-called Bangs' Disease or contagious abortion in cattle and is transmitted thru infected milk. Person to person contact is also sometimes effective. The school's contribution to protection against this disease consists in the exclusive use of pasteurized milk and, of course, in the application of the general principle of exclusion of sick children without waiting for a definite diagnosis.

Diseases Transmitted by the Bites of Insects

Malaria

Large areas of the United States include communities or portions of communities in which malaria may be found. Many of these are much farther north than is customarily believed. The *anopheles* mosquito, which is responsible for the spread of malaria, has been found as far north as Wisconsin, altho in the northern states malaria is not as common as it is farther south.

From the standpoint of school administration it is important to recognize the fact that malaria is transmitted by the bite of the female *anopheles* mosquito, which has previously bitten a patient in a transmissible stage of the disease. The malaria parasite spends one part of its life cycle in the blood of the human being and the other in the body of the mosquito. Without going into detail it is obvious that breaking the cycle of transmission involves the following steps:

1. Prevent the breeding of mosquitoes wherever possible; this is a community-wide, not specifically a school, responsibility, but the school administrator is responsible for conditions on school property and he has an obligation to exert all his influence toward the correction of mosquito breeding places so located as to be a menace to school personnel.
2. The exclusion of all mosquitoes from quarters occupied by human beings. The malaria mosquito, contrary to popular belief, does not bite only at dusk, but may bite at any hour of the day; this includes school hours. Screening of school buildings in malarial or potentially malarial regions is therefore an obligation of the schools and so is intensive education and leadership looking toward the screening of all buildings used for human habitation.
3. The treatment of persons suffering from malaria is not only a measure of medical care but a preventive measure because as far as it is possible to remove clinical sources of malaria the chances of infected *anopheles* mosquitoes are correspondingly reduced. The mosquito does not generate malarious infection spontaneously; she requires the patient as a source. This treatment should, of course, be done outside the schools, but the schools should not hesitate to take their full share of responsibility for seeing that the malaria patient is adequately treated as a measure of prevention.

Yellow Fever

Yellow fever is not at present a problem in Continental United States, but there is always the possibility of its reintroduction thru airplane travel from tropical areas in which it is prevalent. Its transmission resembles that of malaria but involves another species of mosquito (*aedes aegypti*). Elaborate precautions taken by the United

States Public Health Service[10] should be familiar to school administrators.

Dengue

In a few regions in the United States the disease known as dengue, or break-bone fever, may occur. This also is a mosquito-borne infection for which the *aedes aegypti* mosquito is responsible. It is subject to the same control measures as yellow fever.

Typhus Fever

This should not be confused with typhoid fever, altho its clinical course may sometimes be deceptively similar. It is spread by the bite of the body louse or the flea. In certain sections of the United States it appears to be far more prevalent than is commonly recognized. As far as the schools are concerned, their protection lies in the rigid inspection of children and exclusion of those who have either fleas or lice. This exclusion is made for reasons of general policy, regardless of the presence or absence of typhus fever, but it remains nevertheless the best protection which the schools have against the introduction of this disease. Exclusion of sick children is also a contributory measure of defense. Since fleas as well as lice may transmit typhus, the eradication of rats and other rodents from which fleas may transfer their affections to human beings becomes important.

Plague

Plague is an Oriental disease which has been held in check in the United States by rigid enforcement of rat control at ports where foreign shipping touches and by constant exercise of vigilance to control in western states the ground squirrels and other rodents in which there is a constant reservoir of plague infection. Plague is transmitted principally by the flea, altho certain forms may be transmitted from man to man by contact. Few school administrators will have any contact with plague, yet the fact that rodents form a constant plague menace lends further point to the eradication of rats whenever and wherever possible.

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[10] Hampton, Brock C "Development of the National Maritime Quarantine System of the United States" *Public Health Reports* 55: 1241-57, July 12, 1940

CHAPTER XI

Injuries and Emergency Illness

In any group of considerable size, sudden illness or accidental injuries are sure to occur from time to time. School children are no exception. It therefore becomes necessary for the school to have a policy with respect to sudden illness and accidental injuries and to make proper provision for carrying this policy into effect.

The general principle which should govern the schools in relation to sudden illness and accidental injury is, in brief, that the school is responsible for the emergency handling of these situations but is not responsible for subsequent treatment. The function of the school, therefore, is to provide facilities and personnel with proper training to act promptly and intelligently in emergencies for the saving of life, the prevention of further injury, and the alleviation of pain as far as this can be done by nonmedical persons. In all such situations the two most important responsibilities are to summon medical aid and to notify parents or other responsible persons.

Experience in many schools indicates that parents may not always be at home to accept notification and responsibility, or they may fail to realize the necessity of taking immediate responsibility. For such eventualities the schools should be prepared in advance by a community plan adopted with legal advice by the schools, the local medical profession, the hospitals, and parent representatives such as parent-teacher associations. Such a plan, adopted in conference and well publicized, should tend toward more uniform and intelligent action in emergencies and should better protect children against possible inadvertent neglect and schools against unjustified criticism. The development of such a plan offers the school administrator a fine opportunity for constructive leadership.

First aid, as its name indicates, should be immediate aid to a person suffering from an acute emergency (either illness or injury). *It should include nothing more.* Too often first aid is visualized, and first-aid courses are organized, to embrace a rather wide field which includes more minor surgery and medical treatment than actual first aid. The true conception of first aid should include only those procedures necessary to save life, to prevent further injury, and to alleviate severe suffering. Above all, it is important to restrain the enthusiasm of the amateur first-aider who has gained a smattering of theoretical knowledge about illness and injuries and is eager to demonstrate his skill. Often what is not done is as important as what is done, or more so.

Variations in General Procedure

Few school systems have a doctor in attendance at every school at all times. Schools where nurses are constantly in attendance are more numerous, but there remain many schools, constituting an overwhelming majority of the total number, in which medical and nursing attendance is intermittent. In many of these, notably the rural schools, a public health official who is a physician may visit the school at long intervals, and nurses, altho present more frequently, will visit the school only occasionally. It follows that, altho the principles are the same and the obligations identical, the methods of meeting emergencies will differ according to the locality of the school and the organization, or lack thereof, of its health services. A general outline of procedures, therefore, is given for three principal types of schools.

Schools with Physicians Present

Schools where physicians are in constant attendance are relatively rare and represent only the largest and best organized school health services. In such a school there should be a first-aid or emergency room, with necessary supplies and equipment for emergency treatment of sudden illness or injury. There should be separate rest rooms for boys and girls. With such equipment and with a doctor in attendance, emergency treatment presents no administrative problem because the doctor is there to take the responsibility. Even so, his responsibility should be limited to strictly emergency care and should end when the family has been notified and has either come for the child, sent for him, or otherwise placed the child in the care of the family physician. Emergency care should not include repeated routine dressings, altho it may, of course, involve the replacement of a dressing which has been accidentally dislodged. Emergency care does not include continuous medication. The routine treatment of the sick, except for emergencies, should remain the responsibility of the family and the physician chosen by them, not of the school. (See Chapter XVI for legal aspects of this question.)

Schools with Nurses Present

In schools where nurses are in constant or frequent attendance the program will necessarily be more limited because nurses cannot properly undertake procedures which would be appropriate for a physician. Such a school should, nevertheless, have an emergency room and certainly should have rest rooms for boys and girls. Its equipment will be simpler than that of the school where there is constant medical attendance. The nurse should properly be expected to take charge of such acute emergencies as fainting, cuts, bruises, stomach upsets, headaches, and menstrual disturbances, but treatment should be limited to simple measures such as rest, the external application of heat or cold, emergency measures for wound cleansing, temporary dressings and hemorrhage control, and ordinary nursing procedures looking to the comfort and safety of the patient. Even if a nurse is present medical aid should be summoned at once if the emergency is serious, and the family should be notified whenever a child becomes ill in school. The nurse should make appropriate arrangements for getting the child home safely when he can be moved, either by having the family call for the child or by arranging other means. Sick children should never be sent home without a responsible attendant.

Schools with Doctors and Nurses Not Present

In schools where neither a doctor nor a nurse is in attendance, provisions for emergency care and first aid will be less elaborate. They will involve little more than facilities for rest and for meeting emergencies in which life may be threatened, such as hemorrhage. In such schools exclusive reliance will have to be placed for immediate action upon several persons of both sexes trained in first aid. As a rule, in such schools a physician should be summoned by the principal or, in the case of one-room schools, by the teacher, if it is impossible to reach the family immediately. The family, however, should be notified first unless the emergency appears to be urgent, in which case the best judgment of teachers or principal must be relied upon to summon medical aid promptly from any source available.

Specific Procedures in All Schools

In all schools, whether doctors or nurses are present or readily available on call, there should be as many persons as possible of both sexes trained in emergency first aid, especially in the control of hemorrhage, the safe handling of patients who are unconscious or who have fractured or apparently fractured bones, and the giving of artificial respiration to those apparently drowned, electrically shocked, or suffering from athletic injuries which temporarily suspend respiration, a condition commonly known as "having the wind knocked out." The ideal is to have every principal and teacher trained in first aid. In any school there should be an adequate supply of first-aid materials and satisfactory directions as to how to use them.

The list of first-aid supplies (see pages 218-19), with suggestions for their use, has been developed by the American Medical Association and is recommended as a basic list, subject to modification according to the instructions of the school medical adviser or a committee from the county medical society. It will be noted that the list contains no drugs. Drugs useful in emergencies should not be used by lay persons because they are all potentially dangerous. Simple drugs for the relief of pain which are safe to use probably include only aspirin, and even aspirin should not be prescribed in school by non-medical persons, including nurses.

Every first-aid room should have a manual on first aid. A list of books having to do with first aid and emergency treatment will be found on page 359 of this yearbook. This volume cannot give full details on first aid, nor is this necessary. Yet it seems advisable to point out certain principles and situations which are too frequently misunderstood.

The following discussion covers a few common situations which may be expected to occur from time to time in the schools, in which it is important that the right thing be done and the wrong left undone. Only a few of the most important situations are given here. Further reading should be done in the reference books.

Major Illnesses

Major or serious illnesses in school children are relatively rare. Most commonly they are severe attacks of communicable diseases, the sudden onset of pneumonia, or occasionally appendicitis or other abdominal conditions. If there is a physician at hand to see the child, his instructions should be followed. If not, nurses, principals, or teachers should make no effort to arrive at a diagnosis. They should, however, be able to recognize the signs of serious illness, which include one or more of the following: unconsciousness; weakness; gray or bluish pallor; fever; dazed or irrational condition; severe pain; cold, clammy skin; or small, rapid, or irregular pulse.

When a child is suddenly seized with one or more of the above conditions, it is important to remember that in many instances speed in getting the child under treatment is the most important consideration. The child should be kept warm and removed immediately to the home. If contact with the home is not made and responsibility accepted by the home within an hour, the school principal or teacher is *justified* in procuring emergency medical treatment, preferably from the child's family physician, if his name is on record, or from the nearest reputable doctor of medicine. In such a case it should be made clear to the doctor consulted in emergency that he may be superseded by the family physician as soon as responsibility is taken over by the family.

Minor Illnesses

Among common minor illnesses are headaches, digestive upsets, toothaches, and earaches. These call for rest in a quiet, semidarkened room and the local application of heat or cold. If the child does not improve promptly he should be sent home. The common practice by which nurses and sometimes teachers give medication for the relief of pain is fraught with danger to the child and possible legal complications for the school system. Even the simplest and safest drugs may give unexpected reactions in unusually sensitive individuals and convert a minor illness into a serious emergency.

In older girls there may be distress accompanying the menstrual period. This, too, calls for rest and for sending the girl home if necessary but not for the administration of any drug whatsoever by nurses or nonmedical personnel.

Even when there is a physician in attendance, it is wiser to avoid the giving of drugs unless the pain is severe and there is no immediate possibility of placing the child under the care of the family physician.

FIRST-AID SUPPLIES AND HOW TO USE THEM

Prepared by the American Medical Association

Suggested Supplies	What They Are For
Tincture of green soap	Washing injured parts
Hospital cotton, roll	Large soft pads or dressings
Absorbent cotton, sterilized, roll, box or "picking" package	Swabs or pledgets for applying medication or wiping wounds
Dressings, large or small pads, sterilized, in individual transparent envelopes	For protecting injuries
Dressings, finger, in envelopes	For protecting very small injuries
Adhesive tape, roll, one inch	Fastening dressings or splints
Scissors, bandage or blunt	Cutting dressings
Toothpicks	For making swabs
Alcohol 70% (water 30%) or rubbing alcohol	Disinfecting skin and minor wounds
Iodine, tincture (dilute with equal volume of water just before using)	Disinfecting wounds which appear to be dirty; do not use on wet skin or on mucous membranes, on face or near sex organs; do not cover with dressings
Other disinfectant, if ordered by physician	As ordered by physician
Mineral oil, bottle, or petroleum jelly, tube or jar, white or yellow, but not medicated	For removing ointments; in eye to relieve irritation from foreign body; for burns if no other ointment is at hand
Boric acid ointment U S P.	For minor burns
Boric acid solution, pint bottle with excess of crystals in bottom	For cleansing wounds and removing dressings which have stuck
Epsom salts	In hot water, a handful to a basin, for *soaking sprains, bruises, or infection,* when ordered by a doctor
Baking soda, powder	Teaspoonful to a pint of warm water, for mouthwash, or gargle if ordered
Salt, crystal or tablets	Same as baking soda, or with baking soda, as directed
Hot-water bottle with cover	Local relief of pain
Ice bag	Local relief of pain
Tourniquet (three feet of soft rubber tubing and a stick or pencil)	Use ABOVE place from where *red blood spurts* Call doctor at once. Release every 15 minutes to allow circulation to reach parts, then reapply
Eye droppers	Cleanse after using and boil before using or rinse with alcohol followed by boric acid solution
Ear syringe, soft rubber	For ears only when ordered by physician
Graduated medicine glass	For measuring liquid medicines
Drugs for internal use.	Only when ordered by physician and as directed by him.

CAUTION

Headache remedies, laxatives, pain killers, and other drugs for internal use are not advised except upon medical advice. They may be dangerous, their habitual use is always undesirable, and may create bad hygienic habits and actually delay the successful treatment of the condition for which they are taken. Commercial antiseptics except for the standard tincture of iodine and such other preparations as the physician may order are not recommended; those which are entirely safe under all conditions are, as a rule, too weak to amount to much. Antiseptic soaps are not better than ordinary soap, and may be irritating. Drugs in "candy" form have no place in a home where there are children.

TABLE OF DOSAGES

A graduated medicine glass is most accurate and should be used whenever possible. In emergency, this table may be used:

20 drops (water solution)	1 cc (metric)
1 teaspoon	5 cc.
1 tablespoon	15 cc
1 wineglass	50 cc.
1 tumbler	250 cc.

Use measuring spoons, not "table" silver

ANTIDOTES FOR COMMON POISONS

The best antidote is not to keep poisons in the home unless absolutely necessary, which it seldom is.

If poisons must be kept, they should not be in the regular medicine chest but in a separate locked cupboard and in containers which attract attention to their contents while being opened. Boxes or bottles containing poisons should have their covers or corks fastened with adhesive tape, or pins stuck thru the cork, to make the user stop and consider before using

If, in spite of all precautions, or because of the absence of precautions, poisons are taken, the following suggestions may help while the arrival of the doctor is awaited

CALL THE DOCTOR AT ONCE WHEN POISONING IS SUSPECTED. FIND OUT IF POSSIBLE WHAT THE PATIENT HAS TAKEN SO THE DOCTOR MAY HAVE SOME WARNING AS TO WHAT TO BRING WITH HIM AT LEAST GIVE THE DOCTOR AS BRIEF AND CALM A DESCRIPTION OF HOW THE PATIENT ACTS AS YOU CAN.

Poison	Signs Which Suggest It	What To Do
Strong acids	Burns in and pain about the mouth, abdominal pain, colic, nausea, vomiting, diarrhea, collapse.	Warm water drinks. Repeat every ten minutes Milk—or egg white, 1 to 2 ounces milk of magnesia.
	If breath smells like garlic.	AVOID ALL OILS.
Strong alkalies	White coating, or burns in or about mouth, colic, nausea, vomiting, diarrhea, collapse	Warm water drinks repeated frequently Lemon juice, dilute vinegar, salt solution —1 teaspoon in 1 glass, repeat in ten minutes
Nerve irritating drugs	Excitement, rapid breathing, abdominal pains and cramps. Flushed face and body. May have nausea and vomiting.	Produce vomiting by 1 tablespoon mustard in warm water or 1 tablespoon of ipecac. Repeat in 15 minutes
Nerve depressing drugs	Drowsiness, slowed breathing, paralysis, unconsciousness, cold, clammy perspiration, face pale, convulsions, fainting.	Produce vomiting—Artificial respiration if necessary. Apply dry heat. Black coffee. Keep patient awake and in motion if possible.
Suffocating gases	Fainting, face pale, slow, shallow breathing, or no breathing.	Lay down in fresh air Keep warm in blankets. Artificial respiration.

Minor Injuries

Cuts, scratches, and abrasions are common. For the most part they are not serious, but occasionally the presence of a virulent organism, such as a *streptococcus,* may give rise to trouble if prompt effective emergency measures are not taken. The most important consideration is cleanliness. The wound and surrounding skin should be gently but thoroly washed with water and soap. Tincture of green soap is safe and effective. A reasonable amount of bleeding helps to cleanse the wound. Simple, unmedicated dressings to prevent subsequent infection should be applied. These dressings must, of course, be not only clean but sterile.

Antiseptics are of minor importance compared with cleanliness. The most commonly used antiseptics are tincture of iodine and various mercurial antiseptics such as mercurochrome and metaphen. If tincture of iodine is used, the mild tincture (3½ percent) is preferable to standard tincture because it is less irritating, less destructive, less painful, and therefore safer. The water solution of mercurochrome (2 percent) is a useful preparation for the treatment of minor injuries. It is less effective than tincture of iodine but also less irritating and less painful.

If any such minor injury shows evidences of irritation or failure to heal promptly, the child should be referred immediately to the private physician selected by the family or, if necessary, to a clinic or hospital outpatient dispensary.

Bruises usually require nothing more than the application of cold, either by ice cap or cold compress.

Repeated treatment subsequent to the first emergency aid is not the function of the schools.

Bleeding

Bleeding is probably the greatest and most immediate emergency which faces the first-aider. Ordinary bleeding, such as nose bleeding, is no cause for alarm unless it is profuse or persistent, in which case medical aid should be sought. Hemorrhage from severed arteries or veins may be serious, depending on the size of the blood vessel. The panic which commonly seizes bystanders in the presence of hemorrhage may be more dangerous than the hemorrhage itself. In most instances visible bleeding is readily controlled by the application of pressure over the vessel which is bleeding. Full instructions as to pressure points for the control of various types of hemorrhage are contained in first-aid manuals and should be memorized and frequently practiced by persons responsible for first-aid service.

Shock

Shock is a condition which accompanies many serious injuries and may sometimes be precipitated in sensitive individuals by severe emotional experiences. It is characterized by a cold, pale, clammy skin, weakness, fainting or unconsciousness, and a thin, rapid, "thready" pulse. The emergency treatment pending the doctor's arrival is rest in a horizontal position with plenty of blankets and hot-water bottles, but with due care to avoid skin burns.

In many instances shock is the only indication of so-called internal injuries. Whenever an individual gives evidence of pain, collapse, shock, weakness, or being "shaken up" more than appears to be explained by visible injuries, the possibility of so-called internal injuries must be taken into account. These may involve injury to the heart, lungs, liver, or spleen. It is always advisable to place injured persons at rest for from thirty minutes to an hour in order that there may be no likelihood of overlooking hidden injuries which may be more serious than is immediately apparent.

Fainting

Fainting is due to temporary lack of sufficient blood supply in the brain. It may be due to many causes. The individual recovers rather promptly but should be allowed to rest, lying down with feet elevated and head low, for thirty minutes to an hour. The most important factor in a fainting attack is to be absolutely sure that it is fainting and not unconsciousness from some other cause. A person who has merely fainted recovers rather promptly because the temporary anemia of the brain is corrected as soon as the individual is no longer in an upright posture. Fainting can often be prevented when it appears to be imminent by having the individual sit down with the knees spread far apart and bend forward until the head is between the knees, thus allowing blood to reach the brain.

Unconsciousness

Unconsciousness from an unknown cause often creates a serious problem in diagnosis not only for the lay person but for the physician. The possibilities are many and need not be outlined here except to point out some of rather common occurrence. These are epilepsy, diabetic coma, and insulin shock. Nonmedical persons should make no effort to differentiate among the causes of unconsciousness but should immediately summon a physician to attend the unconscious person. In the meantime, the patient should be kept warm. To prevent asphyxia the head should be turned to one side so that the tongue will not fall back and obstruct breathing.

Arrangements are now being made to identify diabetic children with cards or identification tags. All children in a school system known to be diabetic should carry such identification, and all such children should be supplied constantly with two lumps of sugar or a whole orange to ward off impending insulin shock. In the case of a known diabetic, especially one taking insulin, the prompt eating of a lump of sugar or of an orange will prevent the occurrence of shock.

Convulsions

Convulsions are relatively uncommon in children today. When they occur they are often of an epileptic type. All that needs to be done in the case of a single convulsion is to keep the patient from injuring himself in falling and to place him at rest. Medical aid, of course, should be summoned at once. In case of recurrent or repeated convulsions the individual should be placed in a tub of warm water pending the doctor's arrival.

Head Injuries

Serious head injuries may produce fracture, concussion, or brain hemorrhage. Unconsciousness is the rule but is not invariable. The individual may merely be dazed. The most common mistake is to assume that rather prompt recovery of consciousness is an indication that there is no serious injury. Patients with head injuries should be kept at rest lying down until a physician permits them to be moved. An ice cap applied to the head is safe and helpful.

Neck and Back Injuries

Neck and back injuries may be merely wrenches or bruises but may also involve fracture. Where neck or back injuries appear to have been sustained the patient should not be moved by those giving first aid but should be made comfortable where he lies. This is especially important because injudicious movements may injure the spinal cord in the area of the important control centers, with possible immediate fatality or permanent paralysis. Even raising the patient's head to give him a drink of water may kill him if he has a broken neck. When persons suspected of injuries of this type are moved, it should be only on a stretcher and not on an improvised stretcher unless absolutely necessary, and preferably under the direction of a physician.

Limb Injuries

Fractures of the limbs involve the possible danger of severing large blood vessels and producing extensive hemorrhage, of injuring nerves, or of bone splinters protruding thru the skin, permitting the entrance of infection. Children with apparent fracture, especially of the legs, should not be moved until the fracture has been properly splinted. They should be kept warm and made as comfortable as possible where they are. It is particularly essential that persons with fractured bones shall not be hauled and lifted into ordinary passenger automobiles and jounced away to the hospital without proper support for the fractured limbs. Persons suspected of injuries of this type should be moved, if at all, only on a stretcher and preferably not on an improvised stretcher unless absolutely necessary.

Burns

Burns, if serious or extensive, require immediate medical treatment. The pain from burns is due to exposure and injury of nerve endings in the skin. Relief is best given by immersing the patient, clothing and all, in warm water, or by applying a thick paste of baking soda. Greasy substances still commonly found in first-aid cabinets are suitable only for minor burns which do not go beyond the stage of reddening. If applied to blistered or destructive burns they complicate subsequent treatment.

Poisoning

Poisoning by swallowed substances should be treated by immediately inducing vomiting with drinks of strong salt water, followed by the giving of large quantities of milk or white of egg to neutralize and take up the action of the chemical as much as possible. No attempt to pass a stomach tube should be made by untrained persons. When calling the doctor it is important to tell him, if possible, what substance or class of substances appears to have been swallowed.

Eye Injuries

Foreign bodies in the eye, or eye injuries, involve the possibility of serious destruction of eye tissues and loss of vision. Unless a foreign body is readily dislodged by the use of simple measures, such as an eye cup, a physician should be summoned. Amateurs should never attempt removal of foreign bodies by the use of instruments. Temporary comfort can be given by placing a tiny piece of white petrolatum (petroleum jelly) or a drop of mineral oil in the eye in which a foreign body is lodged. Injuries in which the coat or wall of the eyeball is pierced require immediate medical attention. In the meantime the patient should be kept quiet, eyes closed, lying down with a loose pad of sterile cotton and a light bandage over the injured eye.

Ear Injuries

Foreign bodies in the outer ear canal are more alarming than serious, especially if a buzzing insect should be the invader. They may, however, be rendered serious by unskilled interference. Justifiable immediate measures include gentle syringing of the ear with warm oil. Water should not be used because certain objects, such as peas, beans, and seeds, which children may put in their ears, will swell when wet and create serious difficulties in subsequent removal.

Foreign Bodies in the Nose and Throat

Foreign bodies in the nose and throat require immediate medical attention. If the object is in the nose, the child may be sent to a physician's office. If it is in the throat, action will depend on whether or not breathing is impaired; if so, the quickest possible means must be taken to bring doctor and patient together. Efforts at removal by untrained persons usually complicate the situation and make it worse.

Foreign Bodies Swallowed

Foreign bodies swallowed usually occasion more alarm than is warranted. Most such objects, even when pointed or sharp, are passed without untoward results unless purgatives are given. It is common practice to feed the individual who has swallowed a foreign body large amounts of soft food.

Athletic Injuries

The problem of athletic injuries is essentially the same as that of emergencies occurring in the ordinary course of school life. The most important responsibility of the school is to prevent athletic injuries to the greatest possible extent and to minimize their seriousness when they do occur (see Chapter VI). Numerous observations have shown that certain definite precautions can be taken to minimize injuries in athletic contests and physical education activities. The principal ones are as follows:

1. Arrange games and contests, especially body-contact events, so that participants will be of approximately equal size, weight, and strength
2. Arrange contests and games only in properly constructed indoor or outdoor play arenas, with appropriate floors, ground surfaces, and safeguards against colliding with fixed structures.
3. Permit participation only by those in good physical condition and with training in skills equal to the average training of other participants.
4. Emphasize the spirit of the game rather than the spirit of winning at all costs.
5. Insist upon prompt removal from participation of any individual who is tired, injured, confused, or for any other reason unable to exert his best skill and effort in self-protection.
6. Select appropriate forms of games and contests to suit the age, sex, condition, and training of participants.
7. Provide necessary protective clothing and personal equipment and insist upon its proper use.

It should be emphasized very definitely that while these preventive measures are the immediate responsibility of the coach, trainer, or director of physical education, they are none the less the ultimate responsibility of the school administrator. If a superintendent or principal takes a strong position in regard to these matters and lets his position be publicly known, any incipient overenthusiasms on the part of coaches or players will be much more likely to be held in check.

While no one can predict who will be injured or when, it is a safe assumption that in any athletic pursuit or physical education program accidental injuries may occur. Provision should therefore be made in advance for the method of handling them. Some schools have a physician present at all major athletic events. Others have physicians on call. Most schools require parental consent for participation in athletics. Such consent should include a clear statement as to who is responsible for the expenses which may be incurred as a result of injury during participation in athletic contests or training and preparation for such contests. Such responsibility may be placed upon the parents, or the school may assume it. If the school assumes it, casualty insurance may be carried to cover possible contingencies. The policy will vary according to law in the several states and municipalities, as well as according to the policy adopted by the school-board. Whatever the policy, it should be clearly defined and carefully explained to the parents of all participants. The legal principles involved are dealt with in Chapter XVI. The prevention of needless injury, as far as it involves the school plant and its operation, is dealt with in Chapter XII.

Notification of Parents

In some communities, problems are created by the fact that children in school may come from homes which cannot be notified during the day if illness should occur because both parents work or are absent from the home for other reasons. It is difficult to advise what to do under such circumstances. In Detroit the problem has been attacked by requesting parents to designate a physician whom they wish to have called in an emergency. The name of this physician is entered on the child's school record card. Other plans may be worked out in other localities thru consultation with school authorities, county medical societies, and representatives of parents, such as parent-teacher association groups.

In case of serious emergency where contact with the home is impossible and no alternative provisions have been made, the school authorities are justified in summoning medical service or an ambulance to take the patient to a hospital. Since laws differ in different localities it will be wise for school authorities to ascertain in advance what may be the legal status of the school or of individuals acting on behalf of the school in circumstances where they are suddenly faced with a situation in which threats to life or the likelihood of severe suffering necessitate prompt and decisive action without parental consent.

Not only children but also teachers and other adult persons connected with the school may suffer from sudden illness or accidental injury. Essentially the same principles apply to the handling of these emergencies as in the case of similar situations involving school children, except that the adult, if conscious, can take his own responsibility in directing what physician to call for subsequent treatment.

CHAPTER XII

Healthful School Environment

ADMINISTRATORS AND TEACHERS should give special consideration to the influence of the school environment upon the development of youth. Too little attention has been given to this problem. We are willing to admit that children are "conditioned" by the school environment, yet remain quite indifferent to actual working situations. School construction has gone forward with too little thought as to how good planning can contribute to teaching efficiency and the avoidance of strain on teachers and children. Since the school contributes favorably or unfavorably to the wholesome development of youth, it is essential to give consideration to the health factors involved in the total school environment. Good results in the improvement of many unwholesome working conditions in our schools will be seen only when the administrative leaders, teaching personnel, and maintenance staff become sensitive to the need for improved physical surroundings.

Growing boys and girls are conditioned by every experience which enters into their lives:

> There was a child went forth every day,
> And the first object he looked upon, . . that object he became,
> And that object became a part of him for the day, or a certain part of
>   the day, or for many years, or stretching cycles of years.
> —*Walt Whitman*

School environment, as considered in this chapter, encompasses every aspect of the school's and the community's influence upon the health of children. The school plant may meet all the requirements of comfort and sanitation and yet be so operated as to lack many of the essentials of healthful living. The influence afforded by a beautiful classroom environment toward healthful living on the part of children may be largely neutralized by a teacher who lacks the skill and grace to give meaning and significance to the setting. The atmosphere created by beautiful physical surroundings and the charm of a radiant teacher personality may be vitiated by the policies of an administrator devoid of the finesse and the understanding necessary to create wholesome human relationships at school. Consideration will be given to the contributions which the school community, the school plant, the teacher, the classroom practices, the organization of the school, and the administration of the program may make toward healthful living.[1]

A Healthful Community

The encroachment of civilization in this hemisphere has left many scars on an environment once lovely and healthful. The story of exploration and settlement on the American continent is one of wastefulness and disregard of the many fine natural environmental factors which the first settlers inherited. The forests were laid waste and the soil abused until it was robbed of its productiveness; then the population moved on to repeat the same cycle on richer lands farther westward. We know now that millions of acres should never have been denuded of their forests and permitted to erode to the point of becoming submarginal lands, practically worthless.

The story of an era of industrial progress is no less destructive of a natural environment once beautiful and healthful. Hills were cut down, mountains bored thru, forests destroyed, and rivers were bridged in order that a new means of transportation could be provided. Highways and railroads were dotted with ugly stations and dirty, insanitary, and unattractive villages. Industries sprang into being, and these were accompanied by one of civilization's monstrosities—the typical American industrial city. In these corporate limits one finds miles of uniformity, acres of unattractiveness, bareness, filth, and little on which esthetic impulses and healthy-minded people can thrive.

We have learned thru experience that the physical environment in which we grow up has important implications in the building of a strong, virile, well-conditioned race of men—healthy in mind and in body. It is indeed encouraging to observe that we are thinking today in terms of recapturing much that has been lost. The interest in reforestation, soil conservation, game conservation, recreational centers, slum clearance, and rural rehabilitation, together with many other signs, indicates a definite trend to make all environment more conducive to healthful living.

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[1] National Education Association and American Association of School Administrators, Educational Policies Commission. *Educational Policies for Community Recreation.* Washington, D. C.: the Commission, 1940. 31 p.

In considering the many factors that may contribute to the health of our school population, we must of necessity concern ourselves with the entire community, whether it be urban or rural. A healthful school situation with respect to the maintenance and operation of the school plant and a health program well planned and conducted will be less effective if the community lacks the essential health services for the prevention and control of disease. Therefore, it is obvious that the school must be concerned with the total health scene in the community and must relate its program to the needs of both youth and adults.

What Schools May Do

Definite standards have been set up for building and safeguarding the health of individuals living in cities, towns, and rural communities. In urban centers the schools may, with great profit, encourage groups of children to examine their communities in the light of accepted standards. Many aspects of their environment can be studied with profit, such as water supply, sewage disposal, fire protection, food inspection, disease control, street safety, slum clearance, and recreational facilities.

Rural schools may with equal profit inquire into their health programs by consideration of their provision for typhoid prevention, malaria control, water supply, toilet sanitation, recreational facilities, and other rural health problems of local concern.

Many instances can be cited where community health conditions have been improved because alert teachers led their students to inquire into certain aspects of community practices which affected the health of the community.[2] For example, in one city the members of the National Honor Society, with an active teacher sponsor, chose as their project for the year a survey of the recreational facilities of their city. They soon discovered that there was a woeful lack of play space for both youth and adults, and further that the program for using the space provided was most inadequate. They invited community leaders to their meeting and presented their findings. A committee chosen from this group called on the city council. As a result of the information gathered by these students and the wide interest created in the community, the council took immediate steps to improve the situation by providing more adequate recreational facilities and raised its budget from almost nothing to $25,000 a year to carry out a greatly enlarged program.[3]

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[2] Particularly stimulating suggestions will be found in the following publications: Hanna, Paul. *Youth Serves the Community*. New York: D. Appleton-Century Co., 1936. 303 p. ¶National Education Association, Department of Rural Education *Community Resources in Rural Schools*. Yearbook 1939. Washington, D C . the Department, 1939. 109 p.

Physical Environment and Delinquency

Those who are interested in the influences affecting the development of normal youth, both physically and socially, should examine the many studies of the influence of physical environment on delinquency. A study of case histories of 1860 delinquent youths in Columbia, South Carolina, covering a period of six years, is quite revealing on this point. Almost without exception the homes of these delinquent boys and girls were in slum areas and remote from recreational facilities. Five of the slum blocks produced more than thirty delinquents each, and eleven other blocks accounted for more than twenty each. It is worthy of comment to note that approximately 75 percent of the delinquent youth were charged with stealing and acts of carelessness and mischief.[4] Living in bare, sordid homes and remote from organized play, they were victims of just "foolin' around."

Studies by Shaw, Thrasher, and others clearly demonstrate that poor environmental conditions are associated with high juvenile delinquency rates. Many of these studies, summarized by the National Commission on Law Observance and Enforcement,[5] show similar community patterns associated with delinquency: (a) the encroachment of business, industry, and other changes forces a neighborhood to deteriorate; (b) dwellings become less attractive and rents decline; (c) low-income groups move in; (d) neighborhood controls thru institutions and community programs disappear rapidly; and (e) the area takes on the physical and mental characteristics of a "slum" neighborhood. Crime and delinquency rates are high in these urban areas which lack wholesome community influences, social solidarity, and constructive public opinion. Educators who fail to recognize and to improve such conditions are taking an unrealistic attitude as to the purposes of education.

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[3] A useful handbook for guiding community study Colcord, Joanna C. *Your Community* New York: Russell Sage Foundation, 1939 249 p.

[4] Report of Children's Committee, Council of Social Agencies, Columbia, South Carolina.

[5] National Commission on Law Observance and Enforcement. *Report on the Causes of Crime.* Washington, D. C.: Government Printing Office, 1931. 2 vols., 390 p. and 401 p.

Relation of Housing to Health

Considerable evidence is being accumulated to indicate that the improvement of the physical conditions of family life insures a decrease in illness and mortality. Rollo H. Britten, senior statistician of the United States Public Health Service, points out: "The existence of excessive sickness and mortality in the recognized slums or over-crowded districts of large cities is an accepted fact. Evidence has been accumulating for many years, both in this country and abroad."[6]

Concrete evidence of the effects of housing upon health is given in an official report from Liverpool, England, where over 26,000 families have been rehoused since 1897. As a result of better housing and other attendant factors, death-rates, tuberculosis rates, and infant mortality rates have been cut nearly in half. An even more convincing report is to be found in a recent article of the National Association of Housing Officials entitled "Better Health Through Better Housing." Statistics concerning general mortality, infant mortality, tuberculosis, influenza, bronchitis, and pneumonia are most revealing. The report further indicates that the workmen in these better housing centers are absent from work approximately half as many days as the workmen from other areas.[7]

The school administrator can no longer remain indifferent to the physical environment of the students who attend the schools under his supervision. He can find from many sources that the regularity of their attendance, their attitudes, and their fitness for successful work at school are determined in part by their physical surroundings while at home. It follows that school leaders must be concerned with the total health scene in the community rather than just the school environment as many of them would prefer. Hence it is of particular concern to the school that its educational program carry over into the home with a reasonable hope that home and community will be greatly influenced and improved.

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[6] Britten, Rollo H. "Housing and Health." *American Journal of Public Health* 28: 957-60; August 1938. ¶See also: *Public Health Reports* 49: 1301-13, November 2, 1934, and *Milbank Memorial Fund Quarterly* 18: 91-113; April 1940.

[7] "Better Health Through Better Housing." *NAHO News*, January 17, 1939 (National Association of Housing Officials, 850 East 58th Street, Chicago, Ill.)

A Healthful School Situation

Wise planning in school construction is a responsibility which the school administrator cannot evade. The tragedy with respect to mistakes made in the location and construction of a school building is that the structure stands for decades as a monument to inefficiency and lack of foresight.[8] The pity of it is that the health hazards resulting from poor location and from a building that is poorly constructed, unsafe, uncomfortable, unhygienic, and unattractive remain to influence adversely the life and work of students and teachers who are forced to work under conditions which wise planning could have avoided.[9] It is a basic assumption of this chapter that quiet and harmonious surroundings, comfortable equipment, adequate light, proper ventilation, effective heating, and other factors calculated to provide a good teaching environment become health assets of first importance.

Selection of School Site

The schoolboard in a prosperous industrial and railroad center with a population of approximately 10,000 decides to build a new high school. Because of the desire to economize, plus the pressure of real estate agents, a site is purchased which is adjacent to the railroad shipping yards. Except for noise the location is adequate and desirable. But the bumping of freight cars and the vibration of the busy yard engine shifting cars all day long destroy the peace and quiet which should surround a school. A large part of the students work in rooms near this incessant noise which serves to distract them from effective work and the quiet pursuit of their daily tasks. The assembly hour, which should stimulate genuine esthetic and spiritual impulses, may be disturbed by the same irritating noises from the outside. That this is not a rare problem is shown by a survey of 846 public-school buildings in city school systems in which 30 percent of the classrooms were almost useless because of disturbing and interfering noise.[10]

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[8] Standards on schoolhouse construction are readily available: the Strayer and Engelhardt series published at Teachers College, Columbia University, New York, a bulletin by Holy published at Ohio State University, Columbus; publications of the National Council on Schoolhouse Construction distributed by the secretary at George Peabody College, Nashville, Tennessee; and publications of many state departments of education

[9] Consult the checklist: National Education Association, Research Division, Safety Education Projects, *Checklist of Safety and Safety Education* Washington, D C the Association, 1939. 30 p

[10] Devereux, Frederick L. "Better Acoustics for the School." *Architectural Record* 79 499-503; June 1936.

Such situations may be avoided by leadership and planning on the part of the superintendent of schools, who should keep schoolboards from making serious mistakes in selecting building sites.

The following procedure is suggested:

1. Prepare for the board a spot map of the student population to be served by the new school
2. Secure data that will indicate population drift. This may be had by
   a. Spot map of building permits for past five years
   b. Past experience and future plans of public utilities, such as gas, electric, and telephone service; and building permits
   c. Study of proposed or anticipated real estate developments.
3. Have the schoolboard adopt definite criteria to guide them in the selection of a building site. The following are suggested:
   a. Prescribe general area in which site must be located (spot map and other data will determine these limits)
   b State the minimum number of acres required
   c. Location must not be adjacent to railways, broken by highways, or near factories or other property where unnecessary noises, odors, or other disturbances would be likely to interfere with the school program
   d. The site should be accessible to the area served—near bus lines, paved roads, or streets as now developed, with due regard to future development
   e The site must be one that can be easily drained and is suitable for recreational facilities, such as tennis courts and ball grounds.

If such criteria were adopted and made public before advertising for a site, a large part of the wholly unusable locations would not be submitted to the board for consideration.

However, many school districts are burdened with old school buildings with inadequate space and surrounded by noise. This calls for careful planning in the light of proper housing. Frequently it is possible to sell the old property and relocate the school in more adequate quarters. If this is not possible, alterations and reorganization may help. Shrubbery massed on the noisy side of the building serves to reduce noise from the street. Relocation of departments to the end that shops and laboratory space utilize the part of the building with the greatest exposure to noise helps to relieve the classroom situation. Further help may be had thru sound insulation and acoustical treatment.

Construction Program

Frequently school buildings are planned and designed by an architect without regard to the educational needs of the community, with the result that the program must be adapted to the facilities provided. The procedure should be reversed. The function of the building should determine the plan. This approach to school construction requires educational specifications as the first step. This phase of school planning should be done by the school administrator with the aid of teachers and other members of the staff. The specifications should indicate the space needed for each activity, and the functions of each activity should be so defined that the architect can make his drawings fit the program which the school proposes to undertake. If the health of the school is foremost in school planning, then rest rooms, toilet rooms, lunchrooms, gymnasiums, nurse's room, and other health needs should be specified before planning for auditoriums and other things less essential to healthful, happy student life.

The hygienic standards generally accepted by school architects in the planning and construction of school buildings under existing building codes are:

1. Adequate protection against fire and other life and health hazards
2. Healthful air conditions secured by effective heating and ventilation
3 Both natural and artificial lighting to prevent eyestrain or development of defective vision
4. Equipment, particularly chairs and tables, constructed and adjusted to meet the individual health needs of children
5. Playgrounds and gymnasiums of adequate size, the latter properly equipped with showers, lockers, and dressing rooms
6. Sanitary provisions for drinking water, toilet, and hand-washing facilities
7. Janitorial service, judged primarily for quality of constructive contribution to the health of pupils and teachers, practical service, and personal influence.

Sanitation—A committee report on "Suggested School Health Policies," representing the viewpoint of a number of medical and educational associations, has the following to say of school sanitation:

> The first consideration in providing the desired type of environment is school sanitation which includes adequate and hygienic lighting, healthful and comfortable heating, proper ventilation, a continuous supply of towels and soap, adequate toilet and washing facilities, modern safety and fire-preventive provisions, ample

play areas, a sufficient number of drinking fountains of approved design, seating which prevents fatigue and encourages good posture, and a school room and school building which are clean and attractive. Standards for school sanitary facilities are frequently found in building codes of state departments of education and sanitary regulations of state departments of health. They are also available in textbooks on sanitation and on school health.

The question of school sanitation is not limited to the provision of sanitary facilities, but includes the instruction of pupils in the proper care and use of these facilities, the housekeeping procedures used in cleaning the building, and the supervision of pupils to see that supplies or equipment are not misused[11]

Water contamination—In the light of recent findings concerning water contamination resulting from defective plumbing, school construction should be done under the most careful and rigid supervision to guarantee as far as possible the delivery of pure water to the school. Regardless of how pure water may be at its source, contamination may enter the water distributing systems in streets or in the plumbing systems of buildings.

There are two principal ways in which plumbing is a factor in making drinking water unsafe. They are:

1 Cross connection of a safe supply with a contaminated supply under pressure which is, or may become, higher than the pressure of the safe supply, and

2 Interconnection of the safe water supply with fixtures or sewers not normally under pressure, but which may discharge their contents into the safe water supply, if (a) pressure develops in the fixtures or sewers from unusual circumstances (flooded streets and sewers), or (b) a negative head develops in any water pipe which has an opening submerged in the contents of fixtures, drains, or sewers.

These cross connections and interconnections have long been common, but epidemics from them occur only at intervals because usually an additional condition must obtain, such as a leak in the check valve between two water systems, before the drinking water will become unsafe.

Dangerous cross connections and interconnections are made by people who are either unacquainted with hazards they create or willing to gamble with the lives of other people on the chance that the extra condition needed to cause water pollution will not occur. Neglect of the fundamentals of hydraulics has been responsible for arrangements which led to flow of sewage into unprotected sources of water supply or into water mains with resultant epidemics and loss of life.[12]

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[11] National Committee on School Health Policies. "Suggested School Health Policies" *Journal of Health and Physical Education* 11: 285, May 1940

[12] Summarized from: Connolly, Joel I, chairman. "Plumbing" Progress Report of the Joint Committee of the Conference of State Sanitary Engineers and the Public Health Engineering Section, A P.H.A. *Ninth Annual Year Book.* American Public Health Association Supplement to the *American Journal of Public Health* 29: 92-98; February 1939

Superintendents desiring to pursue this subject further would profit by securing data on recent water-borne epidemics. Four recent epidemics referred to in Connolly's article are good illustrations of water-borne epidemics and provide a basis for profitable study for sanitary engineers and school superintendents.

Too great emphasis cannot be placed on the responsibility of superintendents and business managers of schools in safeguarding the health of children thru checking the source of the local water supply, careful inspection of school construction, and maintenance of plumbing facilities. Many school buildings are old and need plumbing alterations and improvements. Those in charge should permit no makeshift alterations and should permit no work done except by competent plumbers.

Ventilation—With the possible exception of lighting problems, no area perhaps exceeds that of ventilation and heating with respect to the number and variety of controversial issues. For years discussion has ranged over questions of bacteria, dust, carbon dioxide, and ozone without arriving at many practical conclusions. In the report of the New York Commission on Ventilation[13] it was recommended both from the angles of health and comfort that (a) the temperature of classrooms be kept between 65° and 70° Fahrenheit, (b) some movement or change of air be provided, and (c) humidity should range between 35 and 50 percent. These standards must be adapted somewhat to the prevailing climatic conditions of various regions of the country. Also the seasons of the year and the type of clothing worn by the children must be taken into account.

Beyond the range of these easily attainable standards the heating and ventilation problem becomes one of avoiding stuffiness and discomfort. Body odor, sometimes a factor, resolves itself into personal factors of hygiene and sanitation. It is obvious that eventually much of the ventilation and heating problem is to be solved thru the daily inspection and housekeeping procedures of each classroom.

Lighting—Controversy has raged for many years with respect to the effect upon the eyes of various kinds and amounts of lighting. Schools have been accused of increasing the eye defects of every generation of pupils; few of these critics have made any effort to discover how many children have defective vision when they enter school. Altho there have been a number of surveys of lighting conditions, most of them lack evidence of the long-time effects of certain types of illumination upon the physical efficiency of the eyes or have failed to analyze the amount of light required for different types of schoolwork. On the basis of standard educational tests, Loos concluded that *efficiency in reading* was not improved by the use of 20 to 27 foot-candles instead of 5 to 10 foot-candles of intensity.[14] Loos criticized the standards of the illumination engineers who have recommended 20 to 30 foot-candles under typical classroom conditions.[15] Other investigators [16] have concluded that the recommendations of the illumination engineers "may be accepted as an authoritative summary of professional opinion." Thus the discussion goes on with little agreement except on generalities: (a) provide adequate illumination; (b) distribute the light evenly over the area directly before the eyes; and (c) eliminate sharp contrasts and glare even in the area surrounding that directly in view.

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[13] New York State Commission on Ventilation. *Ventilation.* New York: E. P. Dutton and Co., 1923 620 p.

A new development that may change the problems in the field of lighting is the use of fluorescent tubes. Already reports are being made of the advantages of using such lights in classrooms.[17] Experiments are also being made with colored blackboards and colored chalk. It is to be hoped that some of this research will relate lighting and color to the effect that various educational practices have upon the care and health of the eyes. Some idea of the complexity of such investigations may be obtained from Betts' study, *Visual Problems of School Children*.[18]

Plant Maintenance

The care and maintenance of the school plant are important factors in the total school environment.[19] An untidy, unclean, neglected school building provides a poor environment in which to teach habits of personal cleanliness and respect for public property. On the other hand, the school custodian or janitor finds it practically impossible to keep the school plant in order unless the pupils are taught to do their part. The role of the teacher means much in this regard. An orderly teacher sets the stage for an orderly classroom and provides an atmosphere for establishing good habits of cleanliness and conduct.

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[14] Loos, Leonard E. *An Experimental Investigation of Levels of Intensity of Schoolroom Illumination and Reading Efficiency* Doctor's thesis New York. New York University, 1940 p 84-86 (Typewritten)

[15] Illuminating Engineering Society. *Standards of School Lighting with Suggested Requirements for a School Lighting Code* New York: the Society, 1932.

[16] Berens, Conrad, McFarland, Ross A., and Knehr, Charles A "The Eye and Illumination in Schools" *Proceedings, 1940* National Council on Schoolhouse Construction, Nashville, Tenn Ray L Hamon, George Peabody College, 1941. p. 51-60.

[17] Loos, Leonard E. "Fluorescent Light for Schools" *American School Board Journal* 101· 25-26, 93; November 1940 ¶Masterson, C. T , and Darley, W. G. "Color in the Schoolhouse." *American School Board Journal* 102: 50-52; January 1941.

[18] Betts, Emmett A , and Austin, Agnes S. *Visual Problems of School Children* Chicago. Professional Press, 1941 80 p.

[19] Florida State Department of Education. *School Plant Operation and Maintenance in Southern States.* Tallahassee the Department, 1940 127 p.

The role of the school janitor is so important that the selection and training of the janitor should be given as much thought and care as the selection of teachers. The janitor must be considered an integral part of the school system and recognized as a staff member who can contribute much to any program for healthful living at school. In addition, he may have an important influence on the lives of the students. In many elementary schools he is the only male employee with whom the children have close contact, and many of the boys go to him for advice and help.

The most effective school custodian organizes his work and also the work of his assistants, and keeps constantly informed as to the best methods of cleaning, heating, and the many technical details of the job. There are many sources of help for the janitor which are easily available, some of which are listed in the bibliography of this yearbook. In a number of school systems, study courses are provided for study and discussion of the best methods in heating, cleaning, sanitation, ventilation, fire prevention, and similar maintenance problems. Aside from the new information gained, the exchange of experiences on the part of the members of the janitorial staff is often quite profitable, especially where the staff includes specialists in the various fields of janitorial work.

There is such a general public belief in the value of disinfectants and deodorants that it is necessary to state and restate that there is no substitute for soap and water generously used by an industrious janitor. In order to further substantiate this statement, the following is taken from the *Journal of the American Medical Association,* which gives a brief discussion of the effectiveness of disinfectants and deodorants:

> In combating contagion, modern sanitary practices have eliminated disinfectants for spraying walls, ceiling and floors of school rooms. The source of infec-

> tion is the individual; so long as the infected individual is present in the room, any disinfectant that might be used on the walls or the floor would be of little if any value in preventing infection Removal of the infected individual usually suffices to end the danger of spreading the infection.
>
> Soap and water is the best agent for cleaning floors, together with plenty of fresh air and sunshine It is unnecessary to worry about contagious disease organisms that may be lodged on the walls or ceilings; the same rule applies to toilets and urinals Cleanliness will take care of the whole problem without resort to strong disinfectants In fact, terminal disinfection, such as fumigation with formaldehyde, has been generally discarded as valueless. In the case of lavatories, urinals and toilet bowls, so-called germicides in reality accomplish nothing except covering up the primary odor by the stronger odor of the chemical used[20]

In the school program of health protection, particular attention should be given to the sanitation of toilets, rest rooms, lunchrooms, locker rooms, gymnasiums, shower rooms, and swimming pools. Floors should be thoroly and frequently cleaned, not only for esthetic reasons but also because of the possibility of the spread of epidermophytosis (ringworm of the feet). All shower rooms should be equipped with foot-baths containing solutions for the prevention of ringworm, such as a 1 percent solution of sodium hypochlorite or a 5 percent solution of sodium thiosulphate. The solution should be changed frequently enough to keep it at effective strength and give the foot-bath a clean, attractive appearance. Physical education teachers should not permit the use of unclean gymnasium mats, because mats which are not kept clean may be the means of spreading infections such as impetigo and boils.

Unless swimming pools are maintained in a sanitary condition and properly supervised, they may cause the spread of intestinal diseases as well as respiratory and eye infections. Wherever there is a school swimming pool, operating plans should provide water circulation and adequate chemical disinfection of the water. The school medical adviser should arrange with the health officer for periodic analysis of the water. He should also prepare specific regulations governing the use of the swimming pool, covering such items as the bathing of pupils previous to the use of the pool, the inspection of pupils before they enter the pool, and safety precautions. Besides the precautions just mentioned, there is need for the physical educator to give day-by-day supervision to pupil use of sanitary facilities. Only thru careful avoidance of the health hazards of insanitary conditions may participation in physical education be safe and beneficial.

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[20] Journal of the American Medical Association. "Queries and Minor Notes." *Journal of the American Medical Association* 96: 1098; March 28, 1931.

Rural School Environment

The problem of a healthful school environment in rural communities presents many angles which are quite different from urban centers. In many areas the absence of water systems, sewerage systems, electric current, and other basic health services creates a problem apart from the areas which have these services. Each school community should survey its needs and provide acceptable facilities for proper lighting, heating, sanitation, ventilation, seating, water supply, and sewage disposal. Where teachers are in doubt as to what is adequate or standard, they should confer with their state departments of education and state boards of health.

There is little doubt that many rural schools need to improve their environmental conditions in order to safeguard the health of children while in school. A recent inquiry was addressed to the county health officers and school nurses in California to secure an overview of the specific hygienic conditions which in their opinion needed correction. The response, as reported by Helen Heffernan in the *California Journal of Elementary Education,* May 1941, indicates that much attention should be given to the rural schools in the matter of lighting, seating conditions, ventilation problems, and sanitation. A sampling from reports from counties runs as follows: (a) lighting and heating are our greatest problems; (b) no hot water; (c) improper drainage of schoolgrounds; (d) questionable water supply; (e) inadequate facilities for handling food; and (f) no rest rooms for pupils or teachers.[21]

These responses would likely be similar to rural surveys if made on a nationwide basis. The major problem is not one of fact-finding but one of *action.* Teachers and school leaders should devise some plan to sensitize their patrons to the need of improving the school environment to the end that health hazards may be removed. Information regarding approved methods for water supply and school sanitation in rural areas is easily available to interested persons. The need is one of action. Identify in each school the items that need improvement and find some solution. Again we repeat, *action*

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[21] Heffernan, Helen "The Health Program in Rural Schools" *California Journal of Elementary Education* 9: 235-40; May 1941.

WHOLESOME FOOD—*A practical application of health instruction can be made thru the home economics program and the school lunchrooms. The importance of a diet of safe foods, cleanly prepared and wisely balanced, has been recently emphasized. The school should help the student to practice what it teaches.*

Photograph by
Fort Wayne (Indiana) Public Schools

is needed. If you do not have the necessary information for definite action, refer your needs to your state department of education or your state board of health for specific information, plans, or procedures. The nature of your health problem will determine the agency to which you should go for help.

New and helpful material for the improvement of school health conditions is increasingly available to interested persons. A helpful bulletin, *Plans for Florida's School Health Program,* was issued in 1939 by the Florida State Department of Education, Tallahassee, and the Florida State Board of Health, Jacksonville.

Provision for safe water and sanitary drinking facilities constitutes a real problem in rural schools. In response to this need the Anderson County Health Department, Anderson, South Carolina, devised and constructed a hand pump drinking fountain called the "Flute Sanitary Drinking Fountain for Rural Communities." Blueprints may be had by writing the Bureau of Health Education, American Medical Association, Chicago, Illinois. This citation of a device to provide sanitary drinking water for rural schools is one of many helps which may be had if rural schools will only seek the answers to their problems.

Teachers, supervisors, principals, and other school leaders in rural areas should lead the way in each community in a definite program for the improvement of rural school environment to the end that fewer health hazards may exist in rural schools.

The School Lunch Period

Probably in no other area of school practice is there a greater gulf between the theory and practice of health than in the operation of the lunchroom. Pupils are taught to eat with clean hands, but when lunch hour comes they line up at the lunch counter with dirty hands, because they have neither the time nor inclination to wash, or the school has failed to provide the necessary facilities.

The lunch period should be long enough to permit food to be eaten leisurely and to permit the normal social hour which makes eating a pleasurable experience. The lunchroom should be attractive, spacious, and free from undue noise. It should be so planned and operated that it will serve as a laboratory for practice of the health rules and social manners taught in the classroom. Too frequently school administrators make excuses on the ground that the facilities are not available for desirable lunch quarters because they are forced to conduct school in old buildings that were not planned for a modern school program. To all such we suggest a modest program of remodeling or reorganizing the lunch program to use the old building more effectively.

The following plans became effective by quite different approaches:

1. *School A*, with an enrolment of approximately 700 primary and elementary pupils, had no suitable space for a lunchroom and no facilities for washing hands. At little cost, two classrooms were reconditioned by removing a partition, and with a small investment in equipment an attractive lunchroom was provided. In the corridor just outside the lunchroom a long wash basin was installed and every pupil entering the lunchroom was required to wash his hands. Pupil monitors supervised the program by supplying each child with a paper towel to dry his hands.
2. *School B* in an industrial community had an elementary enrolment of approximately 400 pupils. The school had set as its goal the task of providing a well-balanced lunch for every child. The lunchroom space was woefully inadequate, and no space was available for enlargement. The problem was met by using the available space for food preparation, and the lunches were served in nearby classrooms which were equipped with tables and chairs. Pupil monitors supervised the classrooms during lunch periods and the atmosphere became quiet, orderly, and congenial. Pupils cleared off the tables and left the classrooms neat and clean for classroom activity which followed.

These situations are described to indicate that lunches can be provided under wholesome, sanitary conditions without elaborate equipment and spacious quarters. School administrators should constantly keep in mind, however, the necessity for remodeling old buildings to provide better lunchrooms, better lavatory facilities, and other changes necessary for healthful school living.

School Organization for Health

A healthful school environment requires more than the provision for physical sanitation; it requires consideration of the organization and administration of the activities that take place during the school day. It further requires that consideration be given to human relationships if students are to grow up in a healthful social environment. The attitude of the principal toward health standards can be a vitalizing influence in the life of the school, or he may hinder, by his indifference to healthful living, all the influence of an otherwise ideal hygienic environment.

The school program should be organized to avoid fatigue wherever possible. The student day should be planned with the recognition of the need for relaxation and play periods, the frequency and length of which will be governed by the needs of pupils as they progress from one school level to another. The school should operate to avoid excessive demands on pupils—demands which may overtax their strength and energy. Likewise, the school should operate to remove the strains, pressures, and tensions which may destroy the enthusiasm and pleasure which pupils should experience while at school.

School organization and student guidance can be made a definite part of a program for better sanitation and improved physical environment. One junior high school was faced with the problem of carelessness in the use of school property and a community spirit of vandalism. Thru its student organization a program in good citizenship was set up which changed the spirit of the school concerning the care of property. Thru student organization and interest the school is not only being maintained properly under student leadership but is actually being improved thru a program of interior decorating and landscape gardening. As a result of faculty and student cooperation, many pictures have been donated and hundreds of plants have improved the appearance of the grounds.[22]

Healthful Classroom Environment

In the classroom sphere of the school organization the teacher is the agent primarily responsible for providing an atmosphere conducive to healthful living on the part of her pupils during the school day. The resourceful teacher will not simply adapt herself to the classroom as she finds it but will in various ways change the environment of her room to better serve the needs of her group. She will be concerned with developing and maintaining hygienic conditions within her classroom, building in the minds of her pupils a body of concepts relating to health, and providing opportunities for the practice of desirable health habits as a part of the daily routine. We are concerned here primarily with the first of these since the other phases are treated quite fully in other chapters of this yearbook (Chapters IV, V, and VI).

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[22] Reported from the Hand Junior High School, Columbia, South Carolina (J. R Sullivan, principal).

Good Housekeeping

The importance of cleanliness and order in the conduct of classroom activity and the part they contribute to the healthy growth of children can hardly be overemphasized. Satisfactory janitorial service is an essential phase, but the teacher and the pupils must play an essential role if proper hygienic conditions are to be maintained. Good housekeeping in the classroom is a cooperative undertaking.

Perhaps the teacher contributes most to this cooperative task. Certainly she must accept the responsibility if pupils fail to assist in maintaining clean and attractive classrooms. She is the responsible agent for setting up housekeeping standards and leading students to become active participants in a program for orderly classroom routine. The teacher should set for the group some guiding principles. The following items should be considered as suggestive:

1. The teacher's desk should serve as a standard for the class in good housekeeping
2. Develop the habit of using the wastebasket.
3. Acquire the habit of placing wraps in proper places.
4 Have a place for everything used in the classroom and teach pupils to replace articles following use.
5. Keep desks and table tops free of books and instructional materials at end of day so that they may be properly cleaned.
6 Have a thermometer and maintain normal temperature for health and comfort.
7 Provide as nearly as possible proper ventilation thruout the school day.
8 Adjust window shades for best possible light in keeping with the changing light conditions during the day
9. Appropriate classroom decoration should be encouraged, but teachers should not place posters and plants in windows or use dark window curtains because these obstruct the light.
10. Keep blackboards clean when not in use
11. Train pupils to make suggestions for improvement

This list is merely suggestive. Many other items should be added for a complete checklist.[23]

The wise teacher will set up a program for pupil participation in the maintenance of an orderly and sanitary classroom. Thru participation pupils can be guided to become increasingly responsible for their own materials, the common property of the class, the proper arrangement of the furniture in the room, and many other details which will contribute to an orderly workshop free from health hazards common to many classrooms.

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[23] Williams, Frank, Viles, Nelson E ; and Hamon, Ray L. *School Housekeeping.* Nashville, Tenn., Interstate School Building Service, George Peabody College, February 1940. 16 p.

Teacher Responsibility for Improvement

Many teachers have to work in situations where facilities for keeping a room clean, orderly, and attractive are decidedly lacking. Some buildings are old and in bad repair; cloakrooms are inadequate and poorly lighted; storage and filing spaces are meager or entirely absent. Under such conditions the teacher with initiative will set out to secure some of the basic equipment necessary to good housekeeping. The alert, patient teacher can do much to bring about a program of improvement by bringing the needs of her class to the attention of the proper authorities. If funds are not available, other means may be found. Interested parents and parent groups frequently come to the aid of the teacher if they are made conscious of the needs of the children while at school. In this regard teachers should work cooperatively and not despair if results do not always come quickly, but they should bear in mind that continuous effort will eventually bring results.

Classroom Methods

Space does not permit a detailed discussion of the relation of classroom method to healthy child development. It is important that we point out that the classroom procedures may affect the mental health of children. Teachers should seek to acquire those practices and controls which will promote healthful work atmosphere in the classroom. The absence of undue competition, fear, and physical stress should be constantly sought for the sake of health. "Pressures are brought to bear upon a child by parents and siblings. Excessive pressure of the school upon the child may result in his withdrawing or in his attempting to gain success in undesirable ways. It is a strain for a younger child to keep up physically and mentally with children who have longer spans of attention and greater endurance and mental alertness."[24] Teachers should therefore think of their teaching methods, practices in classroom control, teaching devices, promotional policies, and every other phase of classroom procedure in their relation to, and bearing on, the development of children. It would be futile to attempt prescription. There is no one formula for developing a health-teaching situation. There are things basic, but every teaching situation is an individual one and a challenge. Some teachers become so intent and intense concerning their plans that they inhibit rather than inspire youth in achieving worthy goals. In short, the teacher who exhibits sympathy and understanding of the problems and needs of children will better provide an atmosphere for healthful living at school.

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[24] National Education Association, Department of Elementary School Principals *Meeting Special Needs of the Individual Child* Nineteenth Yearbook. Washington, D. C.: the Department, 1940 p. 282.

Esthetic Influence in Healthful Living

The importance of esthetic surroundings has been admitted for centuries. Despite this general admission, many teachers have failed to comprehend the full significance of the real influence of an attractive classroom as a health factor. Many classrooms still remain drab and unattractive when alert, creative teachers with some effort could transform these rooms into healthful, attractive places for living. Children, too, may be stimulated to participate in a program of improving the classroom environment. Thru cooperative effort on the part of the art, shop, and home economics departments and the students of each group, classrooms can be so treated and individualized as to create a new atmosphere in the building. Such an undertaking will give the students of the school a stimulating experience and will tend to develop in them a keener appreciation of the value of the beautiful in life.

Only a beginning has been made on the possibilities of using color in the classroom to give impressions of roominess and coolness or to promote relaxation. The experimental rooms in Ironwood, Michigan, painted with pastel shades of salmon, vermilion, and chrome yellow, have been reported as "easy on the eyes."[25] The effect on lighting of the colors used for walls and ceilings merits further exploration.[26] Certainly a New Hampshire teacher was both scientifically and esthetically right when she complained about the "bilious green color" of her classroom.

The classroom teacher has a definite opportunity and also a responsibility for developing in her room a physical environment favorable to healthful living. Her room should be a laboratory in which pupils will begin to strive for the improvement of their surroundings. The classroom experiences should also develop in youth that keen sensitivity to their environment which will cause them to become uncomfortable in the presence of crude, inartistic, and insanitary surroundings. Youth, so conditioned, will likely become an active participant in adult life in the improvement of living conditions.

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[25] Cameron, Donald "Color in the Classroom." *American School Board Journal* 101 20, 87; November 1940. ¶Also Erickson, Arthur E "An Elementary School Painted for Children" *American School Board Journal* 102: 49-50, May 1941

[26] An interesting new school using colors and homelike design is described in "Under the Stars We Advance," *American Home* 26 10, 12, November 1941.

The care which we exercise to protect youth against contagious diseases should also be exercised in developing those attitudes toward life which are necessary to happy, healthful living. The importance of the school environment in this connection can hardly be overemphasized. Beauty is one of the fundamental human desires. Youth is particularly sensitive to attractive surroundings. One of the obligations of the school is to provide an atmosphere in which youth may have healthful experiences. Such an atmosphere cannot be provided if children have to spend their formative years in school buildings with unkempt grounds, ugly architecture, poorly decorated walls, insanitary toilets, too little light, and drabness everywhere. The fact that the life of many children at home is colored by mean and sordid conditions increases the obligation of the school to provide these youth with healthful and beautiful surroundings. The school has a large obligation to such children if they are to inherit the satisfaction of healthful living.

Human Relationships

The classroom is a laboratory in which there is at work the interplay of all the forces—physical, mental, moral, social, and spiritual—which are found in adult life. The teacher who can guide youth thru their perplexities to the point where they form those valuable habits, wholesome attitudes, and reactions which result in harmonious living together will contribute much to the health of the school and the community. The teacher is the key to healthful living at school. She should exhibit health in her appearance and work habits at school. Youth will reflect her enthusiasm, voice, manners, and health practices. This being true, her responsibility is great. She has the obligation for developing in her pupils the calmness, poise, attitudes, and habits essential to wholesome development. Teachers, therefore, should aid youth to develop the appreciations and capacities which will enable them to get the greatest values to be had from healthful living.

CHAPTER XIII

Functions and Preparation of School Health Personnel

A CHILD'S CHANCE OF RECEIVING ATTENTION from appropriate school health specialists varies with the size of school systems. If a few thousand are enrolled, the individual child may expect the services of a school physician and there is a fair chance that he will see a school dentist. The presence of a nurse in the school is taken for granted. If the school system's total enrolment stands in the hundreds, the child may see a part-time school nurse, the only health education specialist employed by the school. In the larger school systems he will, if he requires attention, have access to such specialists as psychologists, psychiatrists, nutritionists, and oral hygienists, and his experiences in health education will develop under the direction of specialized instructors and directors much more frequently than in the smaller school systems.

Some types of specialists currently provided in school systems of various sizes are indicated in Table 3.[1] It should be noted that the figures do not represent the numbers of individuals in the various classifications. Since some of these specialists give only part-time service in the schools, the figures indicate the numbers of specialists whose full-time work would be equivalent to the total time actually given by the persons employed.

Little agreement is evident in the number of specialists for a given number of school children. In individual school systems these numbers will vary with the financial ability of the cities involved and with the amount of cooperative service available from other agencies. The emphasis placed by the school administration on health education is perhaps the strongest determining factor.

The School Physician

In Table 3 the school physician, or medical adviser as he is coming to be known, appears in a ratio which varies from one for 2000 children to one for 16,000 children. These are, be it remembered, merely ranges in current practice as sampled, but the cities report-

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[1] Data from responses to inquiries sent to selected school systems across the country, 1941.

TABLE 3.—NUMBER OF SPECIALISTS PROVIDED IN TEN SCHOOL SYSTEMS

School system	Number of children in system	Physicians	Dentists	Oral hygienists	Psychiatrists	Psychologists	Nutritionists	School nurses
A	100,000	46[a]	7	7	1	1	1	44
B	50,000	3	0.4	......	......	4	1	24
C	50,000	4	1.5	1	0.5	......	......	18
D	25,000	5	3	8	0.04	1	1	21
E	15,000	3	0.5	2	......	1	......	11
F	6,000	2	1	1	......	......	......	2.5
G	2,500	0.5	......	......	......	......	1	1
H	1,000	......	......	......	......	......	......	1
I	350	......	......	......	......	......	......	0.5
J	200	......	......	......	......	......	......	0.6

[a] Forty of these physicians, working five to seven hours a day in the schools, are paid jointly by school and health boards.

ing are all favorably known for their work in health education. The optimum medical service in a school system must be determined by its own changing requirements. It seems doubtful that one school physician can be greatly helpful to individual children when he is responsible for them by the thousands. Most schools are definitely understaffed as far as school physicians are concerned, and current conditions, with their excessive demands on the members of the medical profession, add to the problems of the schools as they attempt to provide adequate medical service for their children.

The functions of the modern school physician are educational. The school requires a medical inventory of the health status of its children, both for their general welfare and to indicate necessary variations in school procedures. The health examination, ideally made in the presence of the parents, serves to screen out children whose conditions require diagnosis and those whose obvious defects indicate a need for immediate attention. To the family physician and to available clinics or other approved medical agencies belongs the responsibility for diagnosis and appropriate treatment. To the school physician and to other members of the school staff belongs the responsibility of result-producing health guidance in cases where action is indicated.

The school physician will cooperate with public health authorities in the control of contagious diseases thru inspection, sanitation, and other educational procedures in the schools. Actual vaccination or other immunization at school may be justified, as other possible cases of treatment by the school physician, only as an emergency measure or as a requisite educational experience. The school physician protects the children from conditions within the school and is instrumental in the development of school health policies. He cooperates with other health agencies in the community, informs those concerned as to the children's health status, and by cooperation and education brings about such conditions as will enable diagnosis and treatment. The school physician in no way assumes the functions of the family physician or of other medical agencies in the community.

Basic requirements for appointment to the position of school physician include completion of the prescribed course in an approved medical school with the degree of Doctor of Medicine, standard service as an intern, license to practice on a permanent basis, and such interest and experience as qualify one to deal with children. The stamp of approval indicated by membership in the American Medical Association is a reasonable requirement. The pediatrician is peculiarly qualified to serve as a school physician. Experience in children's hospitals and in clinics dealing with children is valuable. The physician who is in charge of the school medical service may well have training both in public health and in education.[2]

Happily, passing are the days in which appointments as school physicians are given to young members of the medical profession to tide them over as they establish themselves in practice. Cases in which older physicians eke out their declining incomes by accepting appointments to serve the schools are disappearing. Merit and fitness are coming to be the sole qualifications for appointment. The position of school physician, giving full time to the children, is a career job, deserving the full vigor of the finest professional servants.

Individual school physicians included in Table 3 are more numerous than the figures indicate. Many specialists serve part time. Included are eye, ear, nose, throat, pulmonary, and cardiac specialists, and others in the fields of nutrition and endocrinology. In some instances their services are arranged for on a definite schedule of partial school hours; in others they are on call. The latter arrangement may be preferable, provided there is no hesitancy in calling for necessary services because of their addition to the medical budget. Only in the largest school systems will it be possible for many specialists to devote all their time to the schools. It is a wisely directed school system that makes their services available as they are required by the health program.

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[2] Kleinschmidt, Earl E "An M.D. and More Is the Present Day School Physician." *Nation's Schools* 19: 35-36; May 1937.

In the smallest school systems, as shown in Table 3, the school physician disappears from our list of specialists employed by the school authorities. Children in rural schools are largely without medical supervision in the schools altho, in increasing instances, the services of physicians employed by central agencies are made available over a relatively wide area. Many small schools rely largely on full- or part-time nurses in the schools with such medical cooperation as may be made possible thru organizations in the community and by grace of physicians who give their services to the schools in an enlightened spirit of social service. The inadequacy of school medical service is greatest in the small school systems and in isolated schools, generally in areas where such services are most vitally needed.

The School Dentist and Dental Hygienist

Dentists appear in the schools with less frequency than physicians. Even in the largest school systems they are apt to serve on a part-time basis. With less than the equivalent of one full-time dentist in a school system with more than 50,000 children enrolled, not much direct work can be expected in the way of dental inspection, referral to agencies, and direct dental education. Under these circumstances the dentist hardly can be expected to do more than to stimulate dental interest among members of the teaching staff. Efficiently done, such stimulation can be highly effective. In cases where dental hygienists are employed they usually equal the dentists in numbers.

Ten states definitely authorize boards of education to provide dental treatment, but schools ordinarily are not empowered to supply such service except when parents or guardians are unable to meet the need or when necessary services cannot be provided thru a more appropriate agency.[3] Under usual conditions the work of the school dentist supplements that of the school physician, adding details to the inventory of the health status of the children. His examinations result in statements concerning such dental conditions as may require treatment by the family dentist or some other agency. Periodic dental examinations are educational in their effects, and children's experiences with school dentists can be of prime educational importance. It is their responsibility and that of other school officers to see that follow-up results in the dental care and corrections which are necessary.

The dental hygienist serves as the dentist's receptionist and examination assistant. When she appears in schools she takes charge of records and makes them available to teachers and others concerned with health guidance activities. It should be emphasized that the dental hygienist works under the direction of the school dentist and that her service as a dental educator lies in the work she actually performs. It is not recommended that dental hygienists become part-time classroom teachers.

Requirements for appointment as a school dentist include the standard training of a recognized school of dentistry with the degree of Doctor of Dental Surgery. The dentist must hold a permanent state license to practice, and his standing may be further assured by membership in the American Dental Association. His specialization and his postgraduate work will, ideally, concern the dental problems of growing children.

Present requirements for dental hygienists are comparatively low in some of the reporting cities. In certain instances, only an elementary education is necessary to qualify applicants for a competitive examination on whose results appointments are based. In others, completion of a one-year course is required. Two-year courses are available, leading to the degree of Graduate Dental Hygienist.

The comparatively small number of school dentists does not mean that most school systems are ignoring the dental problems of their pupils. It is true that too much reliance is placed on sporadic dental drives, with occasional examinations by dentists who contribute school examination service. If such examinations are repeated at irregular, widely spaced intervals thru the years, each successive examination is apt to reveal approximately the same number and variety of necessary corrections. To be effective, dental examinations and service must be secured at relatively short intervals.

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[3] National Education Association and American Association of School Administrators, Educational Policies Commission *Social Services and the Schools.* Washington, D. C · the Commission, 1939. p 79.

Some experiments have interestingly indicated that a comprehensive program of dental education in the schools, with intelligent efforts to stimulate awareness of the need for dental health and the means by which it may be achieved, can produce results which approximate those resulting from the services of dentists in the school. The dentist's educational work can be of infinitely greater importance than is his work in filling children's temporary teeth.

Psychologists, Psychiatrists, and Visiting Teachers

Psychologists appear in a considerable portion of the larger school systems. Their original appointment was usually brought about by the insistence of academic problems and the recognition of individual differences among children. Potentially influential with respect to child health, psychologists may play a minor role if they content themselves with measuring intelligence and achievement, and ignore emotions and human relationships. It is important to know the academic capacities of children and the extent to which their possibilities are being achieved, but this is not enough. Many school psychologists find early that their problem cases are problem cases because of conditions quite apart from the classroom and that they must discover the mental, emotional, and social causes for their maladjustment. In many instances they must take an active part in bringing about fundamental changes in the schools to make possible the adjustments which are required. In smaller schools the psychologist assumes functions usually assigned to visiting teachers. Where this occurs, his training should include more social work than is usually expected in a psychologist's preparation.

The training of school psychologists for many positions is not required to exceed that required for the master's degree, with specified courses in the psychology of learning, educational psychology, educational measurement, and statistics. Such training is not superior to that of many competent teachers engaged in classroom instruction. Unless his native insight and the easy effectiveness of his professional relationships set him apart from other teachers with similar qualifications, these requirements do not appear to be adequate. The tendency is not only for an increase in the total requirement of training but also for the requirement of training in social service relationships. Experience in social work and in teaching is valuable. The psychologist needs to be equipped to deal with the child rather than with a limited area of the problems which beset him. Pennsylvania is one of the few states with standards for the certification of school psychologists.

Full-time psychiatrists appear in only a few of the largest school systems. It is doubtful if full-time service is required in the typical school system, but the need for psychiatric service is not met by the occasional assignment of difficult cases to a part-time psychiatrist. It is important that his services be employed in the development of school policies and programs. He can be of great service in bringing teachers to know whether psychiatric or educational treatment is required in given instances.

Because of school budget limitations, psychiatrists are found more frequently in child guidance clinics which serve the entire community than in the schools. Such placement makes their services available to all the children in the community but has the disadvantage of disassociating them from conditions of instruction. There is a tendency on the part of some psychiatrists to assume that schools are institutions similar to those they attended in earlier years and that their ways are fixed. Reports from teachers indicate that psychiatrists may diagnose cases and expect teachers to provide appropriate treatment or may suggest procedures which are not in harmony with school activities. Closer relationship with the schools will give the psychiatrist more of the children's background, will put him in touch with their development while under his care, if they are continued in school, and will enable him to advise temporary adjustments in school plans as well as to bring his influence to bear on changes which can be made in a period of years.

To be eligible for appointment psychiatrists should hold diplomas from the American Board of Psychiatry and Neurology. This board issues a special diploma to candidates who seek standing as specialists in nervous and mental disorders. The diploma is issued only after a careful appraisal of the candidate's educational background, the character of the men under whom he has worked, his hospital and clinical connections, his original investigations and his contributions to psychiatric literature, his affiliations with professional societies, and his professional and general reputation. Such consideration protects the public in a field which has been subject to unfortunate exploitation.[4]

Many visiting teachers have backgrounds of understanding and successful work in classrooms. Their ideal preparation includes four years in a school of education with courses in the psychology of childhood, of adolescence and delinquency, educational and experimental psychology, and educational sociology. A year of preparation in social case work involves courses in child welfare, behavior problems, general case work, community organization, and methods for visiting teachers.

The visiting teacher's prime function is to help the school study and make essential adjustments for children with behavior and personality difficulties, poor scholarship, and unsatisfactory relationships with their companions before their situations become serious. Her work should complement that of the school nurse. She refers matters of contagion to the nurse, reports on health attitudes in the families concerned, investigates the need for action by other social agencies in cases referred by the nurse, and is of assistance in seeing that children receive needed attention from special clinics. In a similar relationship she provides the school psychologist with personal and family histories in connection with mental examinations, refers cases of suspected mental deficiency to the psychologist, and cooperates in follow-up work, especially with mental defectives. Her function is to bring the right social forces to bear on cases which require them. The visiting teacher is not an attendance officer. She ranks with the teachers of the school and works with them. Again, it is not a matter of a teacher's washing her hands of a difficult pupil thru referral to the visiting teacher, but one of the teacher and the visiting teacher working together to eliminate the educational and environmental factors which interfere with the normal development of the child. She works to the end that the school may individualize its children. She works in the school, with the home, and thru the social agencies to meet the special needs of children.[5]

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[4] Bassett, Clara *Mental Hygiene in the Community* New York: Macmillan Co , 1934. p. 44.

[5] Oppenheimer, Julius J *The Visiting Teacher Movement* New York Joint Committee on Methods of Preventing Delinquency, 1925 Chapter 4, "Relationship of the Visiting Teacher to School Agents and Outside Agencies," p 68-98

Nutritionists

Nutritionists are mentioned in Table 3 as concerned with health education in several of the reporting cities. The positions they fill have resulted from a growing recognition of nutrition as basic to health. It is reported that more than one-third of the nation is inadequately fed.[6] The proportion of the usual family budget that is expended for food, inadequacies of food purchasing power, cases of improper diet in spite of academic instruction relating to nutritive requirements and values, and the implications of war have aroused a laggard interest in this basic health science.[7]

The nutritionist in the school is a food scientist, a teacher, an adviser, and a cooperative agent, whose purpose is to bring children to understand their bodily requirements and to carry over into practice their knowledge of essential food values. She must be primarily an educator, with a scientific attitude and the ability to work with others in the cooperative task of protecting the health of school children and teachers.[8] She deals with individual subjects such as physiology, biology, geography, the social studies, and health as a classroom subject, and with their interrelationships. She is concerned that they shall result in good practice. Too often students have gone from their observation of purposely ill-fed white rats to lunch again on a hot dog and a "coke." The cafeteria, made a part of the school instead of merely a food-serving station, offers manifold opportunities for vital instruction. Lacking a cafeteria, the requirements of the noon lunch nevertheless provide as definite a learning situation. In the high schools, where complete departmentalization results so easily in everybody's business being nobody's business, the nutritionist's approach is from the cooperative side. Nursery-school feeding, available surplus commodities, actual families in nutritive straits, individual undernourished children, and high-school children who are largely responsible for their own diets are only a few of the instances which have come in for cooperative use.[9] Education in nutrition is carried to effective completion only when it results in consistently good nutrition practices. For this, programs of adult education may be required. In a number of cities and counties the nutritionist is given community relationships and responsibilities which enable her to use various approaches to her complex problems. Lacking the services of a nutritionist, schools have done good work thru directing committees composed of interested classroom or subject teachers, a nurse, a physical education teacher, parents, and perhaps student representatives, with a home economics teacher as consultant.

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[6] Rogers, James F , Mackintosh, Helen K.; and Burson, Susan M. "Nutrition Education Throughout the School Program." *School Life* 26 131-32, 136; February 1941

[7] American Council on Education. *What the High Schools Ought to Teach* Washington, D. C · the Council, 1940 p 25

[8] Stone, Harriet. "The Functions of the Nutritionist." *Journal of Health and Physical Education* 9 482-83, 519; October 1938

[9] Van Horn, Rua "Nutrition Education in the Secondary School " *School Life* 26: 200-202, 212; April 1941.

The training of a nutritionist should include broad acquaintance with the sciences which underlie the health processes. She should know the human factors as well as the science of nutrition. Recent extensions of knowledge of food values require continued study if her sciences are to be kept up to date. Since her work is with both teachers and children, she should have background courses in education. Experience as a teacher will be helpful. Because her work will concern parents and community groups and organizations, she should have courses in the social service area. Adequacy of preparation would indicate the equivalent of the master's degree with continuing preparation in the various developing areas of her spacious field.

The Nurse in the School

The nurse is found in the schools more frequently than the specialists discussed in preceding sections of this chapter. In the 1938 census of public health nursing, 3880 full-time nurses were reported to be employed by 2128 boards of education, a remarkable development since the appointment of the first school nurse in New York thirty-six years earlier. Some of the 6717 nurses employed by 1113 local departments of health were assigned on a part-time basis to both parochial and public schools. In the rural areas 6556 nurses were attached to county or district health units or employed by local school districts.

It is suggested that, under ordinary circumstances, a school nurse can render "fairly satisfactory service to 1500 pupils of elementary-school age, or to 2000 to 2500 high-school students, unless transportation takes up too much time." [10] In emergency periods, with foreign populations, and when dealing with children on a low economic level, these figures are beside the point. The situation is different, too, for the public health nurse who spends only part time in the schools. These figures may be considered maximal for effective service under usual conditions altho in the cities cited in Table 3 a lower nurse-pupil ratio is evident.

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[10] National Education Association and American Medical Association, Joint Committee on Health Problems in Education. *The Nurse in the School* Washington, D. C.: the National Education Association, 1941. p. 36.

Education in wholesome living is the primary purpose of the nurse in the school as she applies those principles of public health nursing which are applicable to work with the school child in his total environment of home, school, and community. Her emphasis is upon health in the program of the school rather than upon a school nursing program. No matter by what agency she is employed, the nurse in the school becomes a member of the school staff and contributes to the total educational program under its administrative direction.

The functions of the school nurse have sometimes been confused with those of other professional workers. Many of these functions are closely related to those of the physician. As a result, the school nurse has sometimes been expected to perform duties which are not properly her responsibility or that of the school. The treatment of minor infections and of accidents which have occurred away from the school are examples in point. The clear course is to limit treatment in cases of infection, illness, and accident to emergency treatment only. Such occurrences provide excellent opportunities for the education of both children and parents. The efficiency of the school nurse and the fact that health factors are the cause of much school absence have caused many schools to utilize her as an attendance officer. It is the school's responsibility first to ascertain the cause of absence. If it is caused by illness, the absence becomes the concern of the nurse. Her work is so closely allied to that of the social worker that she is sometimes called upon to assume the social worker's functions. It is her place rather to use the contributions of the social case worker in the solution of health problems.

Sixteen state boards of education have established state certification requirements for school nurses. They may be designated as nurse-teachers or teachers of hygiene and home nursing. Such assignments are more common in high schools. In both elementary schools and high schools, nurses have many times been called upon to give health talks and demonstrations. Unless they are specially trained, such random, outside assistance may have serious limitations. More effective has been the procedure which permits the classroom teacher to initiate and to guide the discussion, integrating it with the developmental situation into which it should mesh. The nurse's most effective contribution can be made by continuing close relationships with teachers, keeping them alert to, and informed of, health conditions of the children, home conditions, and family problems involving health.[11]

While the training of many nurses now employed in schools includes only graduation from a recognized school for nurses and registration in their state, the tendency is for this requirement to be increased. In some of the sixteen states with special standards for certifying school nurses, any competent, graduate, registered nurse can meet the requirements for temporary certification, but in each instance where a permanent certificate is issued special preparation in public nursing is required. Some states require a public health nursing certificate from a school approved by the National Organization for Public Health Nursing. Since 1938, thirty hours of professional education beyond graduation from a school of nursing are required before a provisional certificate is granted in the state of New York. Within ten years of service, thirty additional semester hours must be earned to secure a permanent certificate. To be certificated as teachers of health and hygiene for five years in Indiana, nurses must be graduated from a school of nursing and be college graduates with a 24-hour major in public health nursing. Increased emphasis is being given to the preparation of school nurses thru courses in public health and in the principles and practices of education.

In 1938 the National Organization for Public Health Nursing suggested that the following minimum qualifications for nurses appointed to school positions should be effective by 1940.[12] For the nurse in the school system which provides competent supervision, general education should include graduation from high school. Specific training should include graduation from an accredited school of nursing connected with a hospital having a daily average of one hundred patients and instruction and experience in the care of men, women, and children, including patients with communicable diseases. Instruction and experience in out-patient clinics, psychiatric nursing, and public health nursing under a qualified supervisor are desirable additions to the nurse's training. Additional requirements are wisely set for the school nurse who works without competent supervision: at least one academic year of study in a college with an approved course in public health nursing and at least one year's experience under qualified nursing supervision in a public health nursing service in which family service is emphasized. It is desirable that this experience include school nursing. For nurse supervisors a college degree with courses in education is essential, and preparation in the theory and practice of supervision is desirable. Their preliminary training should include at least two years' experience under qualified nursing supervision in a public health nursing service.

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[11] National Education Association and American Medical Association, Joint Committee on Health Problems in Education, *op cit*, p 7-10

[12] Public Health Nursing "Minimum Qualifications for Nurses Appointed to School Nursing Positions." *Public Health Nursing* 30: 108-109; February 1938.

Classroom Teachers

In commenting on the relative importance of various factors which determine the success of a school health program, a director of health and physical education lists as the first essential, "the preparation and participation of classroom and subject teachers." A director of health education considers that "teachers interesting themselves in the problems of pupils" is the most important factor. From the point of view of one school nurse, the essential factor is "close contact with the home and complete understanding among home, teacher, and specialist." It is generally agreed that the teacher occupies a position of the greatest importance with respect to the health education of the children in her group.

In the Elementary School

In the primary division of the school, teachers are concerned with the development of sound health habits. This objective continues thru the intermediate grades, with specific consideration of health problems and principles. In these grades a period may be set aside for health instruction. To be successful, the teacher must be well grounded in facts and principles bearing on health, and she must be alert and skilful in applying them to the children in her group with due respect to school conditions and to other conditions of the children's living. She must understand that health is not only the central concern of the school but that its implications are present in every activity of the school program.

It seems reasonable to infer that preparation for effective teaching in a school which makes a consistent, integrated attack on health problems may best be had in teacher-education institutions where the same fortunate condition exists. In some training schools, however, health is a subject in the curriculum, the concern of a particular department rather than an ideal, persistently and cooperatively pursued. Textbook subjects, activities in physical education, and health appraisals by training-school physicians will not result inevitably in practical, effective applications as teachers guide their children in ways of healthful living. It is essential that facts, principles, and concern for health be given practical application to the problems of teaching.

Investigations within the past decade have shown that the average requirements in health instruction for 162 Class A teachers colleges included, in the four-year curriculums, less than six credit hours in physical education and less than three each in health education and hygiene.[13] Subjects such as sanitation, nutrition, diet, and mental hygiene showed hardly one-half of a credit hour. Yet this is an improvement over 1927, when almost one-half of the teachers colleges and one-fourth of the normal schools failed to offer a course in informational hygiene.[14] In later years improvements have occurred. A greater variety of courses is available. Personal hygiene and mental hygiene are encountered more frequently. The professional content of health education courses has been increased, their personal application is made more frequently, and student teachers are given opportunities to work with real children and to deal with home backgrounds and community relationships. In some advanced situations, materials developed by student teachers are so valuable as to be preserved for the information of later students. In others, the training schools require reports on health education aspects of the teacher's actual teaching after graduation.

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[13] Clements, Mary E *Required Health Knowledge for Prospective Teachers in Class A Teachers' Colleges in the United States and District of Columbia and Legal Health Requirements for Teachers of United States and District of Columbia in 1933-1934* Contributions of the Graduate School, No. 220, Terre Haute, Ind · Indiana State Teachers College, 1935. 129 p. (Unpublished master's thesis.)

[14] National Education Association, Department of Classroom Teachers. *Fit To Teach.* Ninth Yearbook, Washington, D. C · the Association, 1938. p. 228.

Notwithstanding wide discrepancies in credit hour requirements, there is a reasonable agreement as to the experiences requisite to teaching in the health education field. The agreement is general that a teacher must, thru her own health practices, achieve and retain a condition of sound health if she is to teach it with desired results. It is more difficult now for families to consign their less rugged children to lives of teaching. Teachers colleges are stiffening their requirements for personal health at entrance and are following the students thru their courses with health appraisals. Some universities require additional health examinations for students who elect the teacher-training courses. The elimination of students whose health will be a bar to effective teaching occurs as early as possible. In other cases corrections are indicated. Health examinations are given educational significance. Instruction is given in personal hygiene and in mental hygiene. It may be taken for granted that most of the graduates of many teacher-training schools reasonably exemplify the health virtues they will help their pupils achieve.

Ideal preparation for teaching in any field includes broad general education with increasingly intensive specialization in that field. Preparation for participation in health education can be so stated as to leave inadequate time for preparation in other areas which a teacher's work will include The 1932 White House Conference on Child Health and Protection suggested the following specific courses for teachers: chemistry, including organic; bacteriology, including immunology; psychology, general and educational; physiology of infancy and childhood; psychology of childhood and adolescence; and physical education. In addition, specific technical information and training are required: the study of public health activities, including the prevention of communicable and degenerative diseases, sanitation and housing, industrial risks, child welfare, the effect of alcoholic drinks and other narcotics, and vital statistics. Practice teaching is emphasized. In this work the teacher in training will cooperate with the school physician and the school nurse, make observations of physical conditions of pupils and of their health habits, administer simple health tests, gain experience in classroom management and the development of extracurriculum activities, confer with parents on health problems, utilize community health factors as teaching material, and assist in fostering home and school cooperation in health matters. Special attention is properly given to the additional responsibilities of teachers in one-room schools. For them instruction dealing with health inspections, exclusions, and emergencies is suggested. Special instruction in hygiene for boys and girls is advised and more than the minimum of instruction with respect to physical education. Since the teacher in the one-room school serves as her own principal, details of school management and of effective scheduling are important. A course in mental hygiene is suggested. Most textbooks are written with urban situations in mind, so instruction in adapting their material to the use of the groups, which frequently include children from more than one grade in the rural schools, becomes essential.[15]

Completion of such an outline of courses is time consuming. It may not be essential for teachers to experience separate courses in all the subjects whose content contributes to health understandings. Most candidates will pursue courses in general science and biology, perhaps in chemistry and physics, as they meet their general scholastic requirements. Certainly all of them should have unit courses in nutrition, physical and mental hygiene, and physical education. Further courses may well deal explicitly with the materials and methods of health instruction. These courses will include much of the material provided in the technical course recommended by the White House Conference, with the addition of such items as sources of available instructional materials and criteria for their selection; the relation of health instruction to instruction in other areas; and the influence of the school—the building, the neighborhood, the methods of instruction, marking, and reporting, and the spirit which pervades it. Observation and practice teaching in the field should fuse theory with practice.

Modern schools search for teachers whose experiences have brought them to understand that health teaching should permeate the entire school program, whose instruction has resulted in the scientific turn of mind which operates before a background of clear-cut knowledge, and whose bent it is to adapt their health instruction, in class and out, to the total situation in which they find themselves.

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[15] White House Conference on Child Health and Protection *The School Health Program* New York Century Co , 1932, p 290-305.

In the Secondary School

The junior high school presents one of the best opportunities for health instruction. Here the children are at an inquiring age. They are ready for instruction dealing with such areas as personal hygiene, community health, and safety. At the same time, their school's organization may become so departmentalized and their work may become so fully scheduled that the introduction of regular health education classes is difficult. It is strongly recommended that health classes in the secondary schools be directed by teachers with specific preparation in the field.[16] Here again the organization of the school may interfere. Many investigations show that teachers having charge of health classes in both junior and senior high schools are apt to be required to teach one or two other subjects. There is still the regrettable tendency to assign the "basic" subjects and then to fill up incomplete schedules with assignments in health teaching.

If a health teacher can be provided, she should be prepared in her field as definitely as any other teacher. She should have the background of instruction in the sciences—chemistry, biology, physics, and psychology. Her courses in education should include school hygiene, secondary-school organization, and courses in the health field. These may include anatomy, physiology, personal hygiene, nutrition, community sanitation, vital statistics, and some public health organization. Familiarity with their content will be to her advantage if she is to serve as a health counselor to organize, promote, and interrelate the various items of the school's health program. With health courses under the instruction of such a trained instructor and a health council organized to coordinate all school health activities, there is every chance that a health-minded school will result. Without a teacher assigned specifically to the health area, the organization of a health council, with specialists for advisers, can do much to interrelate instruction and to guide collateral activities.[17] When graduate nurses teach courses in home nursing and child care in the secondary schools, they should be equipped with appropriate preparation in teaching.[18]

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[16] Green, Eleanor V "The Organization of Public School Health Education " *Journal of Health and Physical Education* 10. 14-15, 59; January 1939.

[17] Hoyman, H. S. *Developing Health Instruction in Oregon High Schools*. Part I. Eugene, Oreg : State Department of Education, 1940. p 7-8. (Mimeo)

[18] Turner, C. E. *Principles of Health Education* Boston D. C. Heath and Co., 1932 p 261.

It is recommended that a course in health education for one or preferably two semesters be included in the senior high school, with emphasis on racial improvement, public health, and adequate personal and social living. Specially trained personnel should be employed to direct these classes and to serve as counselors and coordinators of health activities. The training of these people should be broad in scope and should include the basic knowledge contained in the health sciences; an understanding of the growth, development, needs, and interests of boys and girls; training in educational philosophy, organization, and method; and a background in the area of guidance. Such training should equal in specifics the requirements noted for teachers in the junior high school.

In the senior high school it is the responsibility of the whole school to teach health. The allocation of a semester or year course in health to the junior or senior year in no way relieves the teachers of related courses of their continuing responsibility to give importance to the health implications of the courses they teach, as noted in Chapter V.

Physical Education Teachers

In the elementary school the present tendency is for classroom teachers to direct the physical education activities of their pupils. These activities include supervised intermissions for active play, as well as specially designated periods for directed work in physical education. A far cry from the ancient calisthenics, physical education activities assume new forms, emerging in rhythms, dancing, club work, camping trips, play days, and informal competitive events in which everyone wins if he does his best. To take charge of this work properly, the teachers must know child hygiene, understand the nature and function of play, be familiar with appropriate activities on the required age levels, and know the most effective methods of teaching physical education for optimum results in health and in social and character development. With careful supervision, classroom teachers' work is highly effective.

In the junior and senior high schools, special teachers are ordinarily assigned to direct classes in physical education. Frequently these teachers have charge of health education classes in alternating schedules in one-gymnasium schools. In many instances physical education teachers are required to teach one or two other subjects, with the result that inadequacies of training are almost inevitable. Extracurriculum assignments are usually heavy.[19] The requirements of physical education teaching are so many and so important that preparation for it should be comparable to that required for teaching in other fields, altho it may be noted that in 1938 only twenty-three states provided laws for physical education teaching certificates. In some of these states a two-year course with no specialization will gain the certificate. In a number of them, the courses are taught by teachers without physical education majors.

Several investigations have dealt with the intelligence and other characteristics of students majoring in physical education.[20] It is frequently recommended that intelligence, personality, character, leadership, and a high standard of school achievement be considered requirements as well as physical fitness. It is recognized, however, that physical fitness has its special value in the physical education field and this value, unfortunately, tends occasionally to predominate. Newspaper mention is frequently made of outstanding gridiron stars who are students in physical education departments, and the inference has been drawn that lower standards in these departments have facilitated their meeting eligibility requirements. Some of these students have gone into teaching after desired connections with commercial athletics have failed to materialize. It is important that professional standards be insisted upon for admission to physical education courses and that requirements for credits, graduation, and certification be comparable to those in other teaching fields.

The physical education candidate faces formidable requirements. He must be well grounded in the fundamental sciences. Certain courses in education are requisite to his understanding of and participation in the general program of the school. In his own field of specialization he must have an array of courses including the principles of physical education, anatomy, body mechanics, physiology, individual requirements, physical examinations, methods of teaching and administration, and health education. These requirements are so extensive as to crowd some general academic courses out of individual sequences and to draw some of the special courses thin.

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[19] Schwehn, Hilda M. "The Educational Responsibilities Outside the Classroom of Women Instructors of Physical Education in the State of Indiana " *Research Quarterly of the American Association for Health and Physical Education* 9 81-96; December 1938.

[20] Monroe, Walter S , editor. "Physical Education." *Encyclopedia of Educational Research*. New York Macmillan Co., 1941. p 810.

In a recommendation covering 128 credit hours, for example, 32 are in the fundamental sciences, 28 in physical education with only one course yielding more than two hours in credit, 12 in education, and 16 in general courses limited to the English field. The remaining 40 hours are made up of special methods, personal technic, observation, and practice teaching, all in the physical education area.[21] Recent suggestions are that the training course be expanded to include five years. The situation becomes more difficult for the physical education teachers who are required, at least in their early experience, to teach one or two other subjects. This requirement may result in uninspired teaching in the other subjects which a physical education teacher directs or in ineffectual physical education teaching by instructors whose major preparation is in other fields.[22] Physical education teachers have reported themselves still in the process of becoming oriented in their positions after a few years of experience in them. Perhaps the practice teaching period should be extended and its scope so broadened as to include a greater variety of the activities in which the physical education teacher will engage.

The guidance, character-building, and socializing responsibilities of the teacher of physical education are more important than his big-muscle activities. His instruction and his promotion of intramural activities are of greater value than the successful records of his winning teams in interschool play, altho some sections of the American public may not hold this opinion. His opportunities for individual work are important. His work leads naturally into recreational activities whose value lies in its carry-over with children as they leave school. The training of physical education teachers and the organization of their instruction should so relate their activities to the general work and life of the school as to reinforce its values rather than to constitute competition with them.

Training in Service

The most successful methods of training the health education personnel in service appear to be those which relate in-service training to the everyday tasks at hand and operate persistently to develop better informed, more capable people thru improvement of their work.

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[21] Nash, Jay B. *The Administration of Physical Education* New York: A. S Barnes and Co, 1931 p 421-26.

[22] Uhler, William P, Jr "Selecting the Teacher of Physical Education" *American School Board Journal* 91· 18-19, July 1935 ¶National Study Committee "National Study of Professional Education in Health and Physical Education" *American Physical Education Association Research Quarterly* 6. 48-68; December 1935.

Many cities have no requirements for ability to teach health other than those necessary for certification. Regardless of their preliminary training, teachers require introduction to new situations. Different objectives, policies, resources, schedules, and routines require interpretation and demand adjustments. Experience in health education gained in one situation does not transfer at once with full effectiveness to another. Physicians, nurses, and other members of the health personnel require orientation in new positions as much as do the teachers.[23] Preparation to fit effectively into a new, unfamiliar situation is training in service of a high order.

Perhaps the easiest way to secure training in service is to require enrolment for summer courses and for afternoon and evening extension courses. Such courses can be valuable, particularly from the factual, informative side, closing gaps in fundamental training. At the same time they may suffer from the handicap of disconnection with the actual work of teachers and others enrolled and become separate units of experience. The condition changes when problem courses are conducted by members of the health staff, such as the psychologist and the directors of health teaching and physical education. The instructional content may then be vital, results doubly beneficial. Instances of teachers and others joining forces, at some expense to themselves, to arrange for extension courses to be presented in the school system and for special lectures to be delivered on subjects of timely, agreed importance have been outstandingly helpful. Conferences and staff meetings should develop on a regular basis and annual institutes may be advisable. In supervision, health specialists will help the teachers to form sound judgments of activities thru which children's health education can be realized, to arrange for suitable instructional materials, and to employ appropriate methods of providing experiences and activities best suited to their groups of children. The school principals will see that teachers have the necessary time and place for their programs and will reinforce their efforts with encouraging administrative support. Classroom visits and demonstration teaching, on occasion, will be helpful. All members of the staff will be encouraged to read widely, to take part in the work of professional organizations, and to relate themselves to community activities and developments.[24]

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[23] Kansas City Public Schools. *A Manual for School Nurses.* Kansas City, Mo.: Board of Education, June 1940 p 4-8 (Mimeo.)

The best training in service is growth in service. The stimulation of such growth is the heart of supervision.

Supervisors and Directors of Health Education

The organization of a school system for health education requires an integrating, directing head if the health program is to be developed properly and successfully related to the other activities of the school program. In the smaller schools the superintendent must accept this immediate responsibility. In others he may rely upon the services of a supervisor or director of health procedures thruout the schools. In the larger systems such a director will rank as the head of a department or division or as an assistant superintendent. In either case he will serve as an active member of the group which confers with the superintendent concerning policy-making and administration.

The recommendation for a master's degree with at least three years of teaching experience may be considered as minimal. In recent years directors have been appearing with preparation in health education and public health, which represents requirements in excess of the usual master's degree. It has been noted that there is no royal road to the directorship of health education. Successful directors have resulted from several disciplines. In some cities the director's background is educational, his experience in the teaching field. Teachers of health and of physical education are represented. Nutrition workers and experts in the field of nursing have been given directive responsibilities, and school physicians have taken over the duties of directors.[25]

The important consideration is that directors of health education shall be influential leaders of the three-dimensional type. Their training in health covers both matter and method. They are familiar with general educational problems and procedures. They are at home in dealing with the complexities of educational administration. The directors duplicate the functions of no specialists, but they are familiar with their work and know how it can best be fitted into the general plan of the schools for health education. Such a position calls for native intelligence, a supple personality, professional maturity, and administrative sense.

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[24] Kelly, Daniel J, and Knowlton, Effie F *A Practicable School Health Program* School Health Monograph No 1 New York· Welfare Division, Metropolitan Life Insurance Co, 1940, p. 20-22, 31

[25] Turner, C. E., *op. cit.*, p. 262-67.

The Administrator's Responsibility

It is the responsibility of the superintendent to establish a school organization which will develop favorable conditions for healthful living. He supplies the personnel, defines their unique and cooperative duties, and serves to integrate all the health activities within the school and to bring them into proper functioning relationships with other activities in the community. His appraisal of the effectiveness of health education in the schools will include not only the attitudes of those concerned, the habits they have developed, and the knowledge they have gained, but also the health status of the children in the school and of the community of which the school is a part. To his schools, potentially a vital health agency, come most of the children of the community, and his responsibility is as wide as the complex social area they represent.

Inescapably, the superintendent's position with respect to the school health program is one of outstanding importance. The final item on an inquiry form dealing with health education asked, "What factor do you think is particularly important in determining the success of a school health program?" From one of the nation's outstanding cities in health education came this succinct reply, "The understanding, interest, and support of the school administration."

CHAPTER XIV

Administrative Practices Affecting the Health of the School Personnel

THE DISCOVERY that the whole child goes to school has exerted a profound influence on education. It is still being talked about, and while some children may be regarded as coming to school sectionally they are generally considered as arriving in one piece.

The agreement that the whole teacher works in the school is not so general. It is agreed that teachers shall not be carriers of transmissible diseases, to the danger of their pupils and their associates. The teacher in frequent ill health is apt to be regarded as unfit for work in the schools, but in many situations the teacher whose instructional work meets minimal requirements is held to be satisfactory. In other situations, more is required. Teachers are expected to be vital, healthy, interesting persons in their own right. They must have the zest which comes from basic good health; the sanity, the emotional balance, and the efficiency which come from well-ordered, well-rounded living. Their personalities reveal resources which are denied the colorless teacher who drags herself to work, who cannot invest herself richly in it, and who has few areas of interest beyond those which concern herself and her immediate tasks and problems. The whole teacher does go to school and it is of prime importance that she shall be so enthusiastic, vigorous, and capable as to make learning and growing the natural reaction of the children whose good fortune it is to be with her.

It does not follow that all healthy teachers are effective, interesting teachers or that some teachers in comparatively poor health are not better teachers than their more robust associates. It is axiomatic, however, that any teacher is a better teacher when she is in good health than when her physical condition barely enables her to report for work. Good health, continuing good health, is fundamental to teaching at its best.

It is a direct responsibility of administration to see that only teachers with the competence of health and vitality are added to school faculties and that the health of teachers in service is protected and developed.

Physical Examinations for Original Appointment

In many school systems physically unfit candidates may, if their defects are not sufficiently obvious to meet the eye of an observant employing officer, receive appointments to teach. Instances are on record in which applicants with active cases of tuberculosis and other transmissible diseases have been placed in teaching positions. Many school systems have required health examinations for their teachers only after the unfortunate, contagious illness of an employee has resulted in community demand for such examinations. In some states whose laws require physical examinations of all teachers on beginning their work, the requirement is quite generally ignored. Not all the larger school systems require these examinations, but the requirement is found to be met less frequently in the rural schools and in the smaller school systems. It is difficult for administration to justify the placement of a teacher who is not known, on the basis of a competent physical examination, to be free from transmissible disease and to be in sufficiently good health to give promise of a successful career (see Figure XI).

The examinations required by a growing number of school systems should influence general practice. A frequent requirement in board of education regulations is one which makes it necessary for applicants to "pass a physical examination given by the Medical Director of the Board of Education, who shall certify that the person is in sound physical health."[1] Examinations under such a requirement may vary from a casual inspection, comparable to the older type of pupil examination at its worst, to a complete health examination with laboratory support. Some schools permit applicants to present certificates from their personal physicians. The form of the certificates is frequently prescribed. Recent examinations are required and physicians' statements may require notarization. The tendency is for boards of education to require these examinations to be made by their own medical officers or in their own cities. It is interesting to note that tenure laws, sick-leave payments, and retirement allowances have quickened interest in the health examination of applicants (see Figure XII).

Attention may be directed to the increasing tendency for requirement of tests for tuberculosis. In cases of positive reaction to tuberculin tests, X-ray films are required. Immunization against smallpox is a frequent requirement. Diphtheria immunizations are less frequently included. Serological blood tests are routine in some cities. The original examination of teachers is assuming many of the characteristics of examinations for nurses who seek appointment to hospital positions. Both teacher and administrator will recognize that rigid examinations may prove to be of incalculable value, both to the prospective teacher and to the children with whom she wishes to be associated.

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[1] Detroit Board of Education. *Directory and By-Laws* (1939-40) Detroit, Mich · the Board p 88

Physical Examinations after Original Appointment

Of the 197 city school systems responding to a questionnaire in 1937, only seventeen provided periodic health examinations for their teachers. In 1941, 289 city school systems provided thoro physical examinations. About one-third required annual examinations; one-third, every three years; one-third, at unspecified intervals.[2]

Arguments for health examinations of teachers on their original appointment apply with equal force to periodic examinations for teachers in service. Examinations are apt to be required routinely of teachers who request sabbatical leave or seek promotion. In many instances health examinations have been demanded of teachers after their necessity has been called to the attention of some person with that authority. Such authority is properly given to the superintendent of schools in many school systems which are without periodic health examination requirements for teachers. Too frequently the resulting examinations have revealed conditions, tragic in their implications, which might have yielded readily to treatment on earlier discovery. Sometimes these conditions have been extremely dangerous to children and others associated with the teacher concerned. The requirement of periodic examinations could have prevented many of these distressing situations.

Under most conditions, annual examinations are advisable. School systems in which annual appointment of teachers is necessary may require a health certificate from the school physician, or from a physician in private practice, before such appointments are made.

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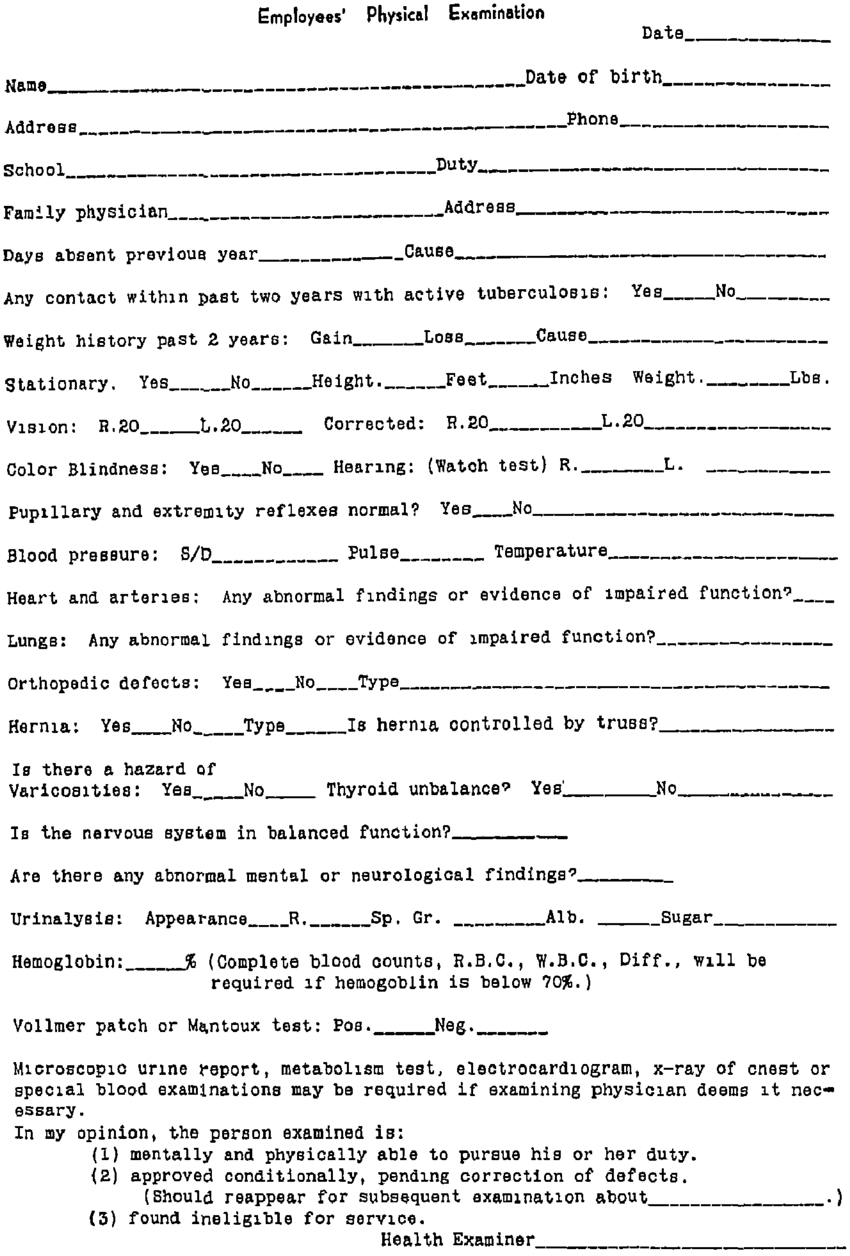
[2] National Education Association, Department of Classroom Teachers. *Fit To Teach*. Ninth Yearbook. Washington, D. C.: the Association, 1938 p. 164 Also preliminary tabulations for 1940-41.



Employees' Physical Examination

Date__________

Name______________________________Date of birth__________

Address______________________________Phone__________

School__________________Duty__________________

Family physician__________________Address__________________

Days absent previous year__________Cause__________________

Any contact within past two years with active tuberculosis: Yes____No______

Weight history past 2 years: Gain______Loss______Cause__________________

Stationary. Yes_____No_____Height.______Feet_____Inches Weight.________Lbs.

Vision: R.20_____L.20_____ Corrected: R.20__________L.20______________

Color Blindness: Yes____No____ Hearing: (Watch test) R.________L. __________

Pupillary and extremity reflexes normal? Yes____No______________________

Blood pressure: S/D__________ Pulse_______ Temperature__________________

Heart and arteries: Any abnormal findings or evidence of impaired function?____

Lungs: Any abnormal findings or evidence of impaired function?______________

Orthopedic defects: Yes____No____Type______________________________

Hernia: Yes____No_____Type______Is hernia controlled by truss?____________

Is there a hazard of
Varicosities: Yes_____No_____ Thyroid unbalance? Yes________No____________

Is the nervous system in balanced function?__________

Are there any abnormal mental or neurological findings?________

Urinalysis: Appearance____R.______Sp. Gr. _________Alb. ______Sugar__________

Hemoglobin:______% (Complete blood counts, R.B.C., W.B.C., Diff., will be required if hemogoblin is below 70%.)

Vollmer patch or Mantoux test: Pos.______Neg.______

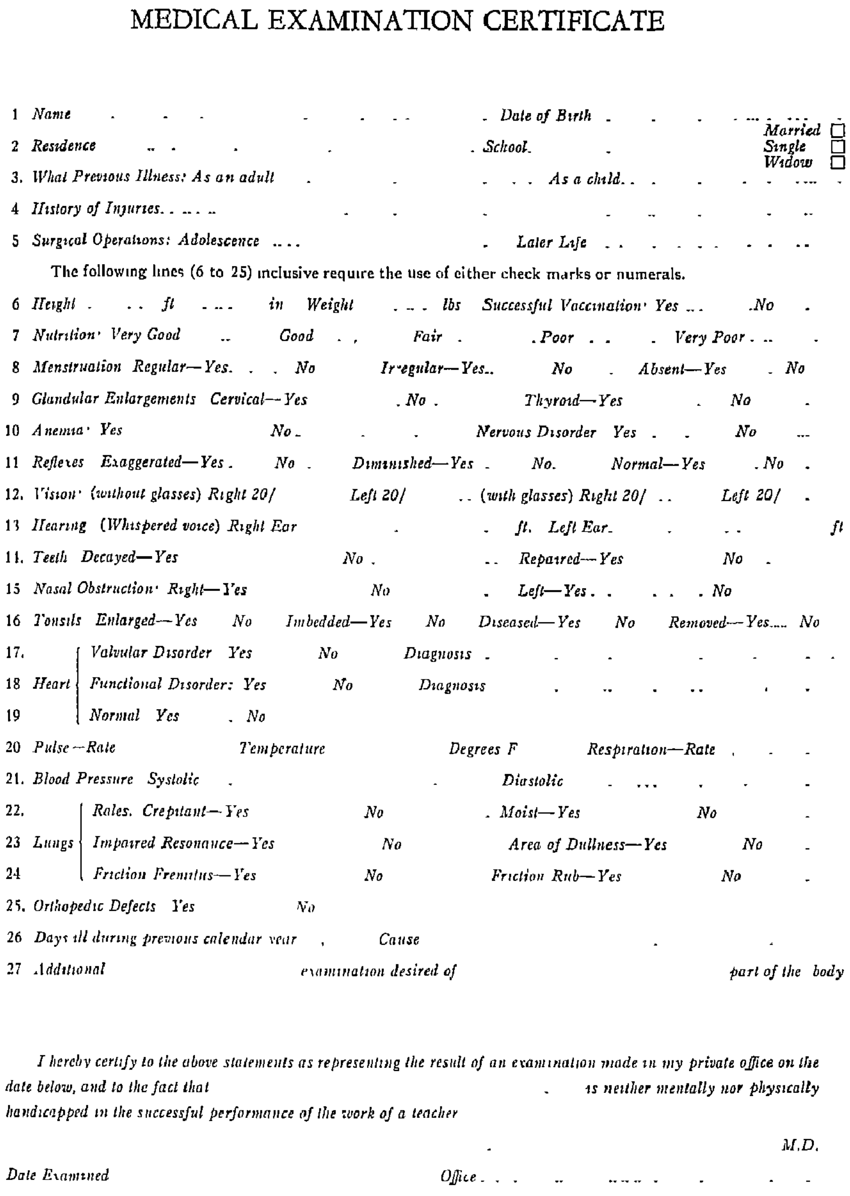
Microscopic urine report, metabolism test, electrocardiogram, x-ray of chest or special blood examinations may be required if examining physician deems it necessary.

In my opinion, the person examined is:

(1) mentally and physically able to pursue his or her duty.
(2) approved conditionally, pending correction of defects.
(Should reappear for subsequent examination about______________.)
(3) found ineligible for service.

Health Examiner__________________________

FIGURE XI.—TOLEDO (OHIO) RECORD FORM



MEDICAL EXAMINATION CERTIFICATE

1 *Name* . *Date of Birth*

2 *Residence* . *School* *Married* ☐ *Single* ☐ *Widow* ☐

3. *What Previous Illness: As an adult* *As a child*

4 *History of Injuries*

5 *Surgical Operations: Adolescence* *Later Life*

The following lines (6 to 25) inclusive require the use of either check marks or numerals.

6 *Height* *ft* *in* *Weight* *lbs* *Successful Vaccination: Yes* *No*

7 *Nutrition: Very Good* *Good* *Fair* *Poor* *Very Poor*

8 *Menstruation Regular—Yes* *No* *Irregular—Yes* *No* *Absent—Yes* *No*

9 *Glandular Enlargements Cervical—Yes* *No* *Thyroid—Yes* *No*

10 *Anemia: Yes* *No* *Nervous Disorder Yes* *No*

11 *Reflexes Exaggerated—Yes* *No* *Diminished—Yes* *No* *Normal—Yes* *No*

12. *Vision: (without glasses) Right 20/* *Left 20/* *(with glasses) Right 20/* *Left 20/*

13 *Hearing (Whispered voice) Right Ear* *ft.* *Left Ear* *ft*

14. *Teeth Decayed—Yes* *No* *Repaired—Yes* *No*

15 *Nasal Obstruction: Right—Yes* *No* *Left—Yes* *No*

16 *Tonsils Enlarged—Yes* *No* *Imbedded—Yes* *No* *Diseased—Yes* *No* *Removed—Yes* *No*

17. *Heart* *Valvular Disorder Yes* *No* *Diagnosis*

18 *Heart* *Functional Disorder: Yes* *No* *Diagnosis*

19 *Heart* *Normal Yes* *No*

20 *Pulse—Rate* *Temperature* *Degrees F* *Respiration—Rate*

21. *Blood Pressure Systolic* *Diastolic*

22. *Lungs* *Rales. Crepitant—Yes* *No* *Moist—Yes* *No*

23 *Lungs* *Impaired Resonance—Yes* *No* *Area of Dullness—Yes* *No*

24 *Lungs* *Friction Fremitus—Yes* *No* *Friction Rub—Yes* *No*

25. *Orthopedic Defects Yes* *No*

26 *Days ill during previous calendar year* *Cause*

27 *Additional* *examination desired of* *part of the body*

I hereby certify to the above statements as representing the result of an examination made in my private office on the date below, and to the fact that *is neither mentally nor physically handicapped in the successful performance of the work of a teacher*

M.D.

Date Examined *Office*

FIGURE XII.—PITTSBURGH (PA.) RECORD FORM

Without the impetus given by the dubious necessity for such annual appointments, it is advisable for teachers under tenure to be subjected to similar annual examinations. In actual practice a shorter form of examination may be given annually, with a complete examination every second or third year. In this connection the following resolution, which was adopted by the Executive Committee of the National Tuberculosis Association early in 1941, may be of value:

> The Child Health Education Committee, with special concern for the protection of children in our schools from tuberculosis, calls attention to statistics from tuberculosis sanatoria thruout the land showing constant admissions of school teachers who have tuberculosis. The Committee therefore recommends that the National Tuberculosis Association, in order to protect children and to safeguard the health of their teachers, take specific steps to advise boards of education everywhere that teachers should be required to present annual evidence of freedom from tuberculosis such as may be provided by a tuberculin test and an X-ray film.

It is important that the health examinations of teachers be carefully and systematically performed. The annual examination should not be merely a routine procedure, casually carried thru. The following frank statement from a teacher exemplifies teacher health examinations in a state of deterioration which should be extremely rare:

> We have a health examination, both for newly elected teachers and also for those already in the system. They must all be examined each year and present a certificate before the first salary check is received. Salaries can be withheld if this requirement is not met. This is particularly to detect tuberculosis. I believe, however, that a teacher could be excluded for any contagious disease or any physical ailment that might interfere with her efficiency, since the rule is stated in very broad and general terms.
>
> In practice the examination is very perfunctory, especially in cases where the teachers have been employed here a long time and have a record of health. Often the school doctor goes from one classroom door to another and checks off names without any pretense of examination. Yet recently every teacher was required to have an X-ray of her chest and lungs, at the expense of the district.

Despite adequate health examination requirements and adequate supervision of teachers' health, the average teacher's absence due to illness ranges from one to almost five days a year in various cities. Some of these absences begin when an administrator notes an unusual physical condition and brings the school physician or the school nurse into consultation. Most of them begin when a teacher decides, of her own volition, that she is unable to report for work or that to do so would provide a source of infection for others in the school. Only in rare instances do these absences begin before they should. In school systems with closely drawn salary penalties for absence due to illness there is a natural tendency for teachers to continue at work when their physical condition does not justify it. Similarly, these teachers are apt to return to work before they should, unless their illnesses have resulted in detaining quarantine or have required the close supervision of an attending physician. Teachers' loyalty, frequently stronger than it is wise, tends to keep teachers at work after illnesses begin and to bring them back to work before their recoveries are complete.

School principals should be alert to the health conditions of the teachers and should not hesitate to request the proper official to require a physical examination of those persons whose physical condition appears to require it. Special attention should be given to teachers who report for work while suffering from severe colds. After absences due to illness, teachers should present a physician's certificate or report to the school physician for examination. School systems differ as to the length of absence for illness which will make a certificate or examination obligatory. Some schools require a certificate after quite brief illnesses, while other requirements begin at three months. It may be said that some brief illnesses offer as great opportunities for contagion on the early return of a teacher as do those of longer duration, altho the hazard for the teacher may be less.

Periodic health examinations, special examinations at any time they may be indicated, and routine examinations on a teacher's return after absence due to illness form an important part of the safeguards for health which administration may properly provide. Such procedures promote the health and efficiency of the teaching force and protect the children in the schools.

Conditions of Employment

All the conditions which affect a teacher's life and work have some effect upon her health. Conditions of employment, salary, tenure, leaves of absence, safeguards for incapacitated teachers, and retirement provisions are definite factors which condition the health of teachers.[3]

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[3] National Education Association and American Association of School Administrators, Educational Policies Commission *Social Services and the Schools.* Washington, D C the Commission, 1939 p 84.

Teachers' Salaries

Comparisons of average incomes in the various professions show school teachers to be poorly paid. Teachers' salaries tend to increase more directly with the size of the community than with the degree of training or the amount of experience. Teachers may add to their preparation and they may gain added experience, but a large proportion of them must remain in the smaller communities. The resort to minimum-wage laws has had only slight effect on salaries above the minimal payments required by law.

An adequate wage for teachers must do more than enable them to maintain good physical health. It must also enable them to participate in their community life as citizens with decent economic standing. Their profession requires it. Underpaid teachers may seek supplemental employment, at the possible expense of their health. This employment can interfere with their continued professional training and compete disastrously with the requirements of their teaching positions. It is a shortsighted community that expects its teachers to prepare its children for the rich living experiences which have been denied these teachers themselves. Every community has an obligation to set aside a proper proportion of its available funds for payment to the competent persons who teach its children. Administration always seeks that these funds may be adequate. Few instances are on record in which these funds are excessive.

With funds in hand, whether adequate or not, the problem of their equitable distribution is pressing. A surprising number of school systems provide no definite salary schedules for their teachers. A common cause of teacher concern is that salary policies provide no increases in compensation for additional training and experience or that, if they are given, no standardized, generally understood procedure is used to arrive at their details. No matter what the level of salary payments may be, a salary schedule whose provisions are known to everyone concerned has value. Some superintendents hold their salary payments to be so low as to make a schedule impossible. Since any salary schedule is merely the statement of the board of education's policy with respect to the payment of salaries, this does not logically follow. It is better for lack of increments in a salary schedule to be known than suspected. It is helpful for teachers to know something of the salary arrangements they may expect next

LIFELONG LEARNING—*The modern educational program offers opportunities to all age levels. Parents and teachers in many communities are continuously studying the natures and needs of children. School libraries should be equipped to facilitate the study of health and other educational problems.*

Photograph by
St. Louis (Missouri) Public Schools

year and thereafter. A teacher's salary in relation to the salaries other teachers receive is psychologically important. The adoption and publication of a teachers' salary schedule and honest observance of its provisions become solid factors in teacher security and peace of mind, important elements of their mental health.

With other professional people, teachers have been described as improvident and lacking in ability to anticipate effectively their requirements in relation to their resources. Assistance from administration by spacing teachers' salaries thruout the year has proved helpful. The teacher whose salary ceases at the close of a seven-month term must live for the rest of the year. In some instances, annual salaries are not large enough to permit them to be divided by twelve with a resulting dividend in dollars sufficient to enable teachers to get along, but the trend for payment of salaries on a twelve-month basis is definite. In 1931 only 15 percent of the city systems reporting to the National Education Association used the twelve-month payment plan. In 1941 this plan was used by 42 percent of the cities.[4]

Adequate salaries, based on a professional schedule, with payments spaced thru the calendar year, are important factors in the physical and mental health of teachers.

Tenure

Two-thirds of the teachers in the United States were, in 1937-38, without definite tenure protection after a probationary period.[5] Almost 40 percent have no protection in their positions other than that afforded by annual contracts. Under these conditions teachers have no basis for a feeling of continued economic security. Fears naturally beset many of them as the time for annual appointments draws near and added worries interfere with their emotional balance.

A properly safeguarded plan for tenure which will guarantee teachers' continuous employment, contingent only on efficient service, is a worthwhile factor in preserving the healthful frame of mind which is conducive to effective teaching.

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[4] National Education Association, Research Division and American Association of School Administrators. *The Twelve-Month Plan of Paying Teachers' Salaries.* Educational Research Service Circular No. 10, 1939. Washington, D. C.: the Association, 1939. p. 4. (Planographed.) Also from preliminary tabulations for 1940-41

[5] National Education Association, Department of Classroom Teachers, *op cit*, p 174.

Leaves of Absence

Absence for illness—It is generally agreed that the good of the schools requires some financial support to be given to teachers who are absent because of illness. Graves has long contended that experienced teachers should be granted leave with pay, no matter what the duration of the absence.[6] Instances of such generous policies exist, but administrators can also find precedent for regulations which provide no pay at all for teachers on sick leave. Almost any amount of sick pay can be justified by at least one working precedent.

The interest of administration in a teacher is not so much in her detailed services thruout a given period of minutes in a series of days as it is in the effectiveness of the years thru which she works. This effectiveness will be less if teachers live in the dread of expensive illnesses with income withdrawn. It will be less if they find it necessary, for reasons of mistaken economy, to report for work when they are not capable of performing their tasks properly and if they drive themselves to return to work before recuperation is complete. Their morale will inevitably be heightened if they can consider themselves consistently permanent parts of the school situation and expect professional consideration which transcends the time clock. On the accounts of health and morale and the superior services which these factors will make possible, a reasonable policy of sick pay is a good investment.

Arguments have been made that liberal sick-pay policies will result in abuse by teachers, but evidence to this effect is lacking. There appears to be no relation between the length of leave with pay and the amount of absenteeism.[7] There is as much basis for the contention that teachers will, under a liberal sick-leave policy, be able to forestall illnesses by early absences for treatments and corrections and thus tend to reduce the number of days of total absence. Superintendents in some of the smaller cities in which sick leaves with full pay are granted indefinitely within the period of a contract year have reported that the teachers value the school system's liberal policy so highly that there is no thought of their taking advantage of it.

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[6] Graves, Frank P *The Administration of American Education*. New York: Macmillan Co., 1932 Chapter 14, "Health Service and Sick Leave," p 267-77.

[7] Threlkeld, Archie L "Cumulative Sick-Leave Plan Is Successful" *Nation's Schools* 17. 30; January 1936.

Information at hand concerning sick leave in the St. Louis schools concerns 3082 teachers in the year 1939-40.[8] The St. Louis regulations permit half pay for each illness, with a 25-day maximum for each instance of absence. During the year, 32.8 percent of the teachers were absent thru illness; the absence for the entire group amounted to 1.25 percent, which is well below the norm. The average absence of teachers was 7.8 days. Of these teachers, 80.2 percent were absent for ten days or less; 9.2 percent were absent from 10½ to 20 days; and 10.4 percent were absent more than 20 days. Fifteen percent of the men teachers were absent at some time during the year as compared with 37 percent of the women teachers. In the elementary schools, 35.9 percent of the teachers were absent, while 26.6 percent of the high-school teachers made use of sick leave. Fairly representative of general conditions, the St. Louis situation is distinguished by one factor in addition to the small percent of absence: the average daily deduction from the salaries of active teachers who are absent because of illness amounts to $5.99 and, since payment for substitutes is at the rate of $5 a day, each day's absence results in a cash saving of 99 cents to the district.

A 1940-41 report concerning sick-leave practices in cities of more than 30,000 showed variances from no salaried sick leave at all up to full pay for sixty days.[9] Few changes appeared to have occurred since the 1928 report, which indicated that the usual practice in cities over 100,000 and in those from 30,000 to 100,000 was to allow ten days of absence due to illness in one year without salary deduction.[10] While the 1941 tendency indicated a reduction in the number of days absence granted for sick leave with pay as compared with 1928, this reduction was offset by an increase in the number of cities adopting the cumulative method of determining sick leave.[11] In 1940-41 the cumulative feature was used in 45 percent of the cities over 100,000; in 44 percent of the 30,000-100,000 group. This trend is more pronounced when it is noted that only 9.6 percent and 14 percent of these cities were making use of the cumulative provision in 1928.

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[8] St. Louis Public Schools, Personnel Division *A Study of Illness Absences of Instructional Employees of the St. Louis Public Schools for the Year 1939-40* 25 p (Typewritten)

[9] National Education Association, Research Division. *Schoolboard Rules Governing Sick Leave for School Employees* Washington, D C the Association, March 1940 31 p. (Mimeo.) Also from preliminary tabulations for 1940-41

[10] National Education Association, Research Division "Practices Affecting Teacher Personnel." *Research Bulletin* 6: 205-56; September 1928

[11] National Education Association, Research Division and American Association of School Administrators. *Employment Status and Leaves of Absence of Teachers, 1937-38* Educational Research Service Circular No 1, 1938 Washington, D. C., the Association, 1938. p. 8. (Planographed) Also from preliminary tabulations for 1940-41.

Various methods may be suggested as typical of groups of cities. In Wichita the five days' allowance of full-paid absence is cumulative for five years. In Evansville the teachers receive two-thirds of their salaries for the first ten days, one-third for the next thirty days. Depending on the number of years of service, teachers may carry credit forward for four years. Albany provides full pay for the first 25 days, deducts $1.50 a day thereafter, not to exceed one-tenth of the time taught, or 200 days. In many cases the amount of sick leave is determined by the number of years of service. The practice of permitting partial payment of salary for some time after the period of full payment has expired is common. Allowances for unavoidable quarantine are usually identical with those for illness.

Absence for rest—A recent report of the Research Division of the National Education Association concerns twenty-one cities which granted extended leaves of absence, with compensation, for professional improvement. Of these school systems, six permitted similar leaves for rest and recuperation.[12]

Various plans of payment were used by these cities. In one instance the flat rate was $800 a year while in two others one-half the annual salary was paid. In two cities the regular salary less the cost of a substitute was allowed, with one city setting $1000 as the greatest payment to be allowed. In one city 1/400 of the annual salary was deducted for each day of leave. Another paid no salary but gave experience credit on the salary schedule for the time spent on leave. In some instances leaves for rest may be granted at the discretion of the board of education, but twenty years of service are prerequisite in most cases. Two cities permit leaves to be extended for a second successive year. The regulations usually provide that requests must be made well in advance of the time at which leave will begin, and such leaves must ordinarily coincide with school terms or years.

Such provisions may well become more general. They enable effective teachers who may otherwise be lost to their schools and perhaps become charges on their communities to recuperate and return to their teaching work. Administrative provisions such as these may be of great value to the health and morale of the teaching force.

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[12] National Education Association, Research Division. *Extended Leaves of Absence for Professional Improvement.* Washington, D C.: the Association, December 1940. 22 p. (Mimeo.)

Absence for maternity—The employment of married women requires consideration of leaves of absence for maternity. In 1940-41 twenty-two of seventy-nine cities over 100,000 employed married women on original appointment; about half permitted women to continue to teach after their marriage.[13] Thirty-eight cities from 30,000 to 100,000 gave original appointments to married women; over one-third permitted women teachers who married to continue to teach. Fifty-six of the larger cities permitted leaves of absence for maternity, as did eighty-six of the smaller cities.

An investigation of the regulations governing such leaves of absence indicates little general agreement among them.[14] In one city, leaves are required to begin as soon as the expectant mother is aware of her pregnancy; in another, as late as four months before confinement. Failure to apply promptly, on awareness of pregnancy, for leave of absence is frequently cited as neglect of duty or as insubordination. The usual leave is granted for one year following the birth of the child, but one city requires a three-year leave. Formal request for reinstatement is a usual requirement and return to work can be expected only when a position for which the teacher is definitely qualified is available. Proof of sound health is a frequent prerequisite to reappointment and the city which grants a leave of three years requires the completion of courses, prescribed by the superintendent, yielding six points or three minors of credit before reinstatement.

These provisions are sensibly directed toward safeguarding the family life of the married teacher, protecting the health of the mother and her child, and insuring the continuance of effective instruction in the schools. These are duties which administration must assume in all school systems in which married women are employed as teachers.

Cooperative Safeguards for Incapacitated Teachers

Teachers may, under stimulation from administration or from direction within their groups, develop methods of guaranteeing salary payments for varying periods and of providing money to cover the costs of illness and hospitalization.

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[13] Preliminary figures from a study by the NEA Research Division, final data to be available in the March and May issues of the *Research Bulletin* in 1942.

[14] National Education Association, Research Division *Leaves of Absence Provisions for Maternity, Cities over 100,000 in Population.* Washington, D. C., the Association, September 1940. 8 p. (Typewritten)

In Columbia, South Carolina, a committee appointed by the superintendent developed a method of guaranteeing the payroll which has proved effective at no great cost to the teachers concerned.[15] Under board of education regulations, Columbia teachers are paid their regular salaries for the first five days of absence due to illness in one year. The cooperative plan provides that, in cases of illness requiring absence of four weeks or more, full salary payments shall be made to teachers who are ill, as of the beginning of the second week of their illness. To finance this plan teachers authorize the deduction of an amount not to exceed 2 percent of their monthly salary checks, but the greatest cost up to this time has hardly exceeded one-half of 1 percent of their annual salaries.[16] Members of the teaching staff cooperate almost without exception in the plan, whose details are supervised by a committee composed of one member of the administrative staff and four teacher members. Since a five- or ten-day absence allowance covers most teacher absence cases, and since absences exceeding four weeks are exceptional, teachers may, at small cost, undertake this form of mutual protection, so vitally necessary to the individuals involved. Teachers in Arizona are reported to have established a plan for group health insurance.[17] Such self-insurance by members of teacher groups offers opportunities for helpful development which appear to have been largely ignored.

Various methods of providing for the costs of hospitalization have been adopted. Group hospitalization plans are difficult in small towns and in rural districts. In Michigan the state medical society's prepayment plan for hospitalization has been adopted by a number of public schools. The state medical association in California is studying plans to adapt the California Physicians' Service to educational institutions that have requested it. The Columbia, South Carolina, cooperative plan for teachers costs members up to $12 a year, and pays a maximum of $150 for twenty-one days. Available forms of group hospital service, nonprofit in nature, provide hospital insurance for varying periods at a cost of seventy-five cents a month and up. It is estimated that approximately 15 percent of the teachers in cities of 10,000 or more were included in this form of contract in 1941.[18] The number of teachers who have purchased insurance with commercial companies issuing hospitalization contracts cannot be determined but is reported by the companies concerned to be increasing.

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[15] Statement of Columbia Teachers' Organization, 1939 (Mimeo.)

[16] Statement of superintendent of schools, March 1941

[17] National Education Association, Committee on Cooperatives *Cooperatives in the United States*, Washington, D. C., the Association, 1941 p. 5 (Mimeo.)

Retirement

If teachers who have some sense of security in their future are able to give themselves more effectively to the exacting work of teaching, then it is evident that the development of teacher retirement systems will add to the effectiveness of instruction.

In spite of the uncertainties of life, many teachers in the cities and states without retirement systems may be quite certain on several points. Their salary payments will not provide savings sufficient for the years of life expectancy after their employment is no longer possible. The three depressions thru which typical teachers pass will cut deeply into their resources. Regardless of retirement funds, if no definite age for retirement is set, teachers must look forward to years in which they will fight a losing battle as they try to continue their teaching work. It is probable that their final teaching will be done under physical handicaps and that their severance from the school system will not result from deliberate planning or occur with the dignity befitting any profession. The dread of disability, thru age, illness, or accident, may weigh teachers down to the point at which their teaching abilities are never actually free.

Thus far denied the protection of the Social Security Act, teachers in thirteen states are as yet without statewide provisions for compensation during retirement. Only one-half of our teachers are under adequate and sound retirement protection.[19] In some states with retirement payment legislation it is possible for teachers of long service to be retired on annuities of less than $100 a year. Average retirement payments in only eight city and state systems exceed $1000 a year. In 1939-40 twenty-four of forty-five retirement systems reported paying average benefits of $600 or less. Reports available show that in the same period twenty-nine of thirty-six systems paid average disability allowances which did not exceed $600. Many teachers look forward to retirement periods which must be financed from their own resources. The means of the more fortunate ones will be supplemented by retirement fund or pension payments which are, in many cases, inadequate. Until teachers are relieved of their dread of helpless, dependent old age, the mental and physical health of many of them will continue to suffer.

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[18] Statement by C. Rufus Rorem, American Hospital Association, April 1, 1941.

[19] National Education Association, Research Division, "Status of Teacher Retirement." *Research Bulletin* 19, 1-64, January 1941.

The health and effectiveness of teachers in the upper-age brackets present matters of administrative concern. In St. Louis, in 1939-40, 142 of the 3082 teachers employed were sixty-five years of age or older, the number being explained by the lack of retirement fund provisions. The average number of days absent was more than three times as great for the group sixty and older as for the group under forty. Thirty-six percent of the older teachers were absent as compared with 29 percent of the younger group. Average absences were longer for the older teachers—12.4 days as against 5.1 days. Figures dealing with teachers of retirement age throw the condition into sharper relief. Federal government retirement provisions usually take effect between the ages of sixty-two and seventy, while under many teacher retirement plans retirement is optional at sixty or sixty-five and is compulsory at seventy. Figures supplied in connection with the St. Louis report show the average absence of teachers sixty-five or older to have been 14.9 days in 1939-40. This is almost three times the average absence of the teachers who were under forty years of age. It is known that many of the older teachers made exceptional efforts to maintain good attendance records to ward off the time when it might become necessary for them to accept limited service status, the St. Louis arrangement for incapacitated teachers which was wisely instituted pending the development of a retirement system. The longer absences of the older teachers cause more definite breaks in instruction. The native vigor of the older teachers may be less while they are present and the continuity of instruction is more seriously interrupted.

The administration of effective retirement fund systems can aid the health and the morale of the entire teaching staff. Specific situations involving disabled or aged teachers can be so provided for as to relieve the persons involved and to protect the children concerned.

Teachers' Life and Work

The health of teachers may be affected by an infinite variety of combinations of conditions inside the classroom and outside the school. Living conditions, community obligations, and school requirements may demand more of a teacher than she can give and retain her health. Teaching requires work and time. Its object is not that it may be made easy but that it may be effective. Administration is responsible for many of the conditions which affect the health of teachers.

Interest in a teacher's living quarters and conditions may be said to vary inversely with the size of the community. In a rural district the teacher's place and mode of living are matters of common knowledge and concern. In the city a teacher's home life and her professional life become separate affairs. The authorities of the school district may not know where she lives, unless they check her name in the directory. Yet it is as important that the newest teacher, with the smallest salary, have a hygienic, comfortable place to live in the city as that any other teacher be properly housed. The concern for a teacher's comfort and well-being at home should be as great in the large system as in the small, and supervision of personnel should accept responsibility for it.

As individuals in their communities, teachers should be privileged to lead the interesting lives of normal citizens. It is an unfair form of community supervision which interferes with teachers' private lives and assigns them, because they are teachers, duties which other persons are privileged to accept or reject. The interests of teachers will lead them into many forms of community participation and service, but they should be Scout leaders, Sunday-school teachers, and choir leaders because of their interest and not because they teach school. Administration will correct specific cases and will work to develop school policies and community practices which will protect the teacher from community exploitation.

In listing occupational reasons for worry and ill health teachers usually assign first place to the numbers of children assigned to them. Many classroom enrolments still run in the forties and fifties, and some are even larger. With departmental groups, teachers may instruct 200 or more children each day. In small schools underpopulated and overpopulated rooms may be found in the same building. With great numbers of children in the classrooms the personal relationship which is basic to good teaching is lost. Teachers are unable to do things they know to be essential. Opportunities slip away. Procedures are compromised. The pride of achievement is lacking and teachers feel spent and frustrated. It is only natural that more ill, nervous teachers are reported under these conditions than when smaller numbers of children are assigned. The quality of teaching necessarily is lowered but, in the case of conscientious teachers, their health suffers first.

For general classroom work there appears to be a tacit agreement that the optimum number of children is somewhere in the early thirties, with larger numbers permissible in activity groups. Finances, building space, and disparity in age distributions may prevent the holding of all class sizes to a reasonable level, but administration will attempt to provide proper conditions for instruction. Current reductions in elementary-school enrolments now ease many situations. Transfers and redistricting may help others. Altho the parents may not worry greatly about teachers' health, they are concerned about their children's instruction and, even without the aid of government grants, can usually be induced to provide sufficient school space for their children.

That even with crowded classrooms administration may make the conditions of teaching easier is evident from the statements of a number of teachers whose class and pupil loads were in excess of 42 and 175 pupils, respectively, that their total teaching loads were reasonable.[20] The teacher with a crowded classroom still has a chance if, with helpful, sympathetic supervision and support, she can attack the problem in her own way instead of applying a general, required formula to a stubborn, outsized situation. Semester admission and promotion policies, with frequent changes of pupils and double programs in many subjects, add appreciably to the teacher's load. The muscular adaptation of promotion standards to meet a no-failure ideal results in teacher strain. The class interruptions occasioned by announcements, bulletins, errands, and special events outranked all other teacher load factors in both elementary and secondary schools as reported in the National Education Association's *Research Bulletin*, November 1939. Choppy, insistent time schedules with brief, inadequate periods can stop a teacher's work before it becomes effective and cause children to seem always in transit, never stopping to learn in the friendly content of a busy classroom. Adequate books and plentiful supplies—items among the first to feel the pinch of a restrictive budget—and clerical help are of great value to the teacher. Apprentice and helping teachers can sometimes take over small groups or relieve the teacher of routine duties. Many classroom services can be taken over by non-certificated employees, freeing the teacher for professional instruction. The special subject teachers can be of greater assistance to teachers with crowded classrooms. The development of activity programs will ease the tension of teaching, relieving the strain of the teacher-focus-of-attention type of instruction.

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[20] National Education Association, Research Division. "The Teacher Looks at Teacher Load." *Research Bulletin* 17: 261; November 1939.

Many teachers report that the problem children in their classes present teaching's hardest problem. Some of them would gladly exchange two or three problem children for a dozen well-behaved, intelligent pupils and carry the heavier numerical load without complaint. It is not always possible to relieve them of their prime pupil irritants. Special rooms help. Coaching classes and emphasis on the solution of the problems of individual children can be of assistance. In some instances the children require placement in a special type of school, whether local or state. A problem dealing with individuals obviously requires individual treatment.

In secondary schools, teachers may be overworked by the assignment of classes in various fields, with as many preparations as classes. Governed largely by the size of the schools concerned, administration can merely see that this problem is handled reasonably in view of the school's enrolment. Attempts to provide broad curriculum offerings may lead to diverse, unsuitable assignments and defeat their excellent purpose. High-school teachers also note inequitable distribution of extracurriculum assignments. Colorless high-school teachers may complete their active day when classroom routines come to a close, while the more capable teachers begin their rounds of clubs, teams, publications, and dramatic groups. Administration may work toward an equalization of these assignments. Few teachers who are capable of good classroom work cannot, with instruction, supervision, and developmental experience, become proficient in some valuable form of extra-class activity. There may be more of stimulation and of value to the school in requiring summer-school courses dealing with an extracurriculum development than in additional courses in the field of the teacher's academic specialization. Extra-class activities can provide personality development for teachers as well as for children.

The workings of the school can affect teachers' health favorably or adversely. Brusque, routine, and unsympathetic supervision adds greatly to a teacher's load. Helpful and understanding assistance from skilled supervisors can lighten it appreciably. Staff meetings, some of which a ready duplicating machine may avert, are deadly and overdone. There is stimulation in meetings which bring teachers into planning and set them on the way of accomplishment. Committee service, dealing with the range from curriculums to the parent-teacher association, can be unfairly distributed. Salary schedules which place undue emphasis on academic credits may force teachers to spend the entire year in a school atmosphere instead of permitting them the health-restoring vacations they require. The substitution of travel for summer-school attendance can be an excellent tonic. Extension classes may compete with teaching work for a teacher's limited energies. Administration must be sensitive to the balance which is necessary for the maintenance of teacher health and see that it is preserved.

It may be noted that conditions of the school plant are as influential on the health and spirits of teachers as on those of children. They, too, react to cheerful, attractive surroundings with high standards for heating, lighting, ventilation, and cleanliness. New school buildings meet the bare codes but too frequently they stop short of providing the final details of comfort and attractiveness which, with a teacher and children, can make a building a pleasant, effective school. Many school systems have an old-building problem. Teachers vie for assignment to the newer and better buildings. Teachers and children in the old buildings feel they are denied the privileges the more fortunate ones in the newer buildings possess. Administration should make the older buildings equal in their basic provisions to the modern schools. Administration may well go further and allot more than a mathematically arrived at proportion of building funds to the older buildings to make them as attractive as conditions will permit. The larger rooms of other days have possibilities for rearrangement. Work rooms, display space, and storage rooms may be contrived. Murals will give the school a lift. Color will still work magic, and rooms do not have to be the same color any more just because they are in the same school building. In all this work of making old school buildings pleasant and attractive, administration will court consistency. It is the repaint jobs that try to make an old model car three years younger that are the most obvious and the least successful.

Administration's Responsibility for the Health of Noncertificated Employees

Figures available from the United States Office of Education indicate that there are more than 250,000 noncertificated school employees in the country.[21] These important people cannot be ignored as school plans and policies are developed. If consideration is given them in educational publications it is too often placed, as in this instance, at the close of a chapter devoted to the problems of the certificated personnel.

It is of great importance that administrative attention be given to the health of these essential employees. The extents to which their duties bring them into contact with children may vary but, save for office and technical employees in the larger school systems, contacts are always possible. It is reasonable to require that general employees such as secretaries, clerks, maintenance men, engineers, janitors, and matrons shall have the same health examinations on appointment and during service as do the teachers. In the case of employees concerned with serving food, especially rigid requirements should be set. These examinations, with accompanying medical histories, will reasonably rule out tuberculosis, typhoid carriers, and venereal disease in a communicable stage.[22]

In recent years many supplemental employees have come into the schools. Some of them are employed by the federal government and assigned to the local school systems. They may be employed to assist with physical education, recreation, and similar activity programs. Others are office people, maintenance assistants, and helping teachers. In many instances such persons are assigned as kitchen employees to assist in the preparation of low-cost meals for school children. In hundreds of schools, parent-teacher associations provide rotating groups from their own memberships or workers employed with association funds to prepare hot lunches in rudimentary kitchens. No matter from what source the assistance is derived, the persons concerned should be given as searching health examinations as are appropriate for permanent employees in similar capacities.

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[21] National Education Association, Research Division "Status of Teacher Retirement" *Research Bulletin* 19, 7; January 1941

[22] Spock, Benjamin "The Changing Task of the School Physician." *Progressive Education* 16· 576-81; December 1939.

Most of the reasons for determining the health of teachers and for protecting it apply with equal force to the noncertificated employees. With respect to transmissible disease, the character of the work done by some of them adds cogency to these reasons.

It is vitally important that all school employees shall be strong, in possession of good health, and free from transmissible disease. They deserve every possible aid of the school administration to the end that they may bring to their work the high efficiency of buoyant physical and mental health. They must be recognized as component parts of a school situation in which the sound health of everyone concerned and the means by which it is protected, conserved, and developed are recognized as essential parts of health education.

CHAPTER XV

Coordination of Health Agencies

THE SUPERINTENDENT OF SCHOOLS should recognize that health is a *community* problem; it is not merely a health department responsibility. The school must be concerned with it, and so must relief agencies; but it is more than a governmental responsibility. In a democracy, health is the concern of the whole citizenry, which also acts unofficially thru its volunteer agencies and thru its medical and allied professions, to which it has a right to look for leadership. School and home relationships and the relationship of the school health program to all these other agencies must be considered in any comprehensive discussion of health in education. Responsibility rests upon the school superintendent and the local health officer for working together to establish an effective relationship between the health program of the schools and that of the community, and for bringing other agencies to their council table to plan, jointly, a community program of health education.

Coordination of effort is possible in the fight against disease just as is the coordination of artillery, infantry, and tank corps in a military engagement. The battle can be waged without coordination but the chances of reaching the objectives are certainly enhanced by coordinated effort. What do we mean by coordinated effort? Coordination means cooperation, working together with clear lines of delineation and articulation; it does not mean merging, subordination of the rightful interests of individuals and groups, or authoritarian dictatorship from any one agency. It means an agreement upon the objectives desired and the acceptance of appropriate activities and responsibilities by each agency, based upon a clear understanding of what is to be done and upon a sane and sympathetic appreciation of the capacities of each group. To continue our military analogy, it means a clear-cut definition of tasks and appropriate timing, with different types of personnel moving forward in the same area at the same time. It does not mean that the infantry will be disbanded, that the colonel of artillery will outrank the colonel of infantry, or that the tank corps officers will give orders to artillerymen.

Reasons for the Coordination of Agencies

It is necessary only to look at the overlapping of responsibilities of agencies in a typical community to see the importance and practical necessity of coordination. The school system is concerned with the health education of adults as well as of children. Both the school superintendent and the health officer seek to promote and protect the health of pupils and teachers. The school system wants a quality of school housekeeping which will protect health and facilitate schoolwork. It looks to city health, police, and fire departments for maintaining sanitation and safety, but it cannot legally or morally delegate its responsibility in these areas.

The school has within its own hands the opportunity and responsibility for so organizing its program that teachers and children have a healthful school program. On the other hand, it is equally concerned with protection against communicable diseases which, by law, is a responsibility of the local health department. It seeks to help the child improve his physical and mental health and to avoid placing burdens upon him which he is physically or mentally unable to bear. But in achieving both these objectives it may look to the family physician or to a physician furnished thru the department of health as well as to the school physician. It would be ideal if every child received adequate medical attention from the private physician. But many children because of poverty or ignorance at home do not secure adequate medical and dental care, and schools have taken the responsibility of finding the needs of the child and, where necessary, the further responsibility of helping these children to obtain medical attention from suitable nonschool agencies.

The local health department exists to protect and promote the health of all citizens, including school children. It is concerned with the healthfulness of the school environment as it is with the whole problem of environmental sanitation in the community. It has an obligation either to inspect the sanitary conditions of schools or to assure itself that satisfactory inspection is being made. In a somewhat comparable way the police and fire departments are concerned with safety in schools. Similarly, the health department cannot delegate its responsibility for communicable disease control. It may approve a program of communicable disease control carried out by school personnel or it may operate its own program with the cooperation of the schools, but final responsibility rests upon the department of health.

Home interests and responsibilities for the health of the child underlie the work of both the school system and the health department. The home is the primary social unit; it has the primary responsibility. If the family lives hygienically and secures adequate health guidance from the family physician, the work of both the schools and the health department is greatly reduced. Life in the family has already determined the mental and physical health of the child before he enters the school. His health as well as his education are joint responsibilities of the home and the state, demanding cooperative and coordinated effort. Because physicians and dentists provide health care and guidance for the family they are vitally important in any program of community health.

Relief agencies become concerned with the health of children whenever the home finds itself financially unable to meet its health obligations to the child. The school is not a relief agency but an educational agency. It does not properly operate clinics or feed children from the school budget, but it is concerned with securing the appropriate use of these agencies by school children.

Many private or volunteer health agencies, representing the best citizens of the community, are concerned with health problems which touch school children. Tuberculosis associations are concerned with the high case-rate at the teen age, particularly among girls, and they recognize the importance education plays in the whole program of tuberculosis prevention. The American Red Cross is interested in improving the quality of home nursing and first aid. The safety council, in its promotion of safety, finds that much of its program must be directed to the school-age children. Parent-teacher organizations have established programs to detect and correct the defects of preschool children and to build community support for the initiation and conduct of a good school health program. The county medical and dental societies often cooperate in outlining a health plan, in providing examinations, and in obtaining the necessary corrective services.

A democratic society should not minimize the importance of these and other local groups which are concerned either with the solution of some special health problem or with the general welfare of the community. These organizations naturally will be interested in coordinating their programs with the school health program. When they are under wise leadership, they will not expect to superimpose their own program upon the schools from the outside. Obviously, any school system which opens its doors to a variety of independent and disassociated programs coming in from the outside will so disorganize the educational process that it cannot effectively serve the child. Coordination of effort and cooperation in the conduct of sound programs, on the other hand, would seem desirable.

Thus we see that some form of coordination is necessary whether school health personnel is employed by the school system or by the health department. Experience reflects good programs under each arrangement, and the trend toward health department or school system employment of this personnel appears historically to have been more closely related to the availability of funds than to any other factor. Thus, while no one particular administrative procedure seems indispensable, some clear-cut agreement as to how the work is to be done seems really essential.

In the field of education the school cannot delegate its responsibility. Society is demanding that its activities be extended to groups both younger and older than the traditional school-age groups. The health department concerns itself with the health education of another part of the general public. For the health department to say that everything that has to do with health must be administered by it, and for the school system to say that all education in the community must be administered by it, would be equally absurd. On the other hand, the health department must be concerned with the professional quality of health services carried out in the schools, and the school system must be concerned with the educational outcomes of those same services no matter which agency employs the personnel.

Obligations related to these interests go even further. The school has the obligation to assist the health department program because it is a great social and educational agency which can profoundly influence the community, and it has facilities, records, and resources of tremendous value in promoting community health. Conversely, the school may properly draw upon the resources and facilities of public health agencies in the planning and conduct of its program. The object of education is to improve the quality of life. Health education does that, and it does it best when most directly related to the health problems of the individual and the community. The health department is unique in the extent of its knowledge concerning health needs, health programs, and health facilities.

There is a natural relationship between health education in the school and in the community at large. The most important health problems in the community need emphasis in school health education. The organization of a community to solve its health problems cannot afford to overlook the tremendous educational force of the public school. The school system and the health department can hardly avoid joint planning. Certainly the citizen would expect some coordination of the efforts of school systems, health departments, police departments, fire departments, welfare departments, clinics, and relief agencies in the promotion of health and safety.

Coordinated Community Health Education Programs

In most communities, school health education and public health education each had a separate genesis. Today there is a sound and increasing tendency to coordinate these two phases of the health education program in the community. A recent study of *Community Organization for Health Education*[1] showed that community planning in this field has often arisen on the initiative of the school system, sometimes on the initiation of the health department, and at other times thru the organization of a planning committee proposed by one or the other of these agencies or by a private health organization. Sometimes coordination was secured thru informal agreement between the health officer and the superintendent of schools. In some communities there was a joint committee; in others a health education coordinator was employed jointly by the health department and the school system, working under the direction of the health officer and the school superintendent, and concerned with health education in the school and in the community. It has been suggested that the health officer should be a nonvoting member of the schoolboard and the school superintendent a nonvoting member of the board of health.

In some of these programs all health activities within the school were carried out by school health personnel, with the public health aspects of the program operated under procedures approved by the health department. At the other extreme were programs in which the medical, dental, nursing, and sanitary inspection services for the school were all provided by the department of health. In one community studied, even the director of health education was on the health department payroll, altho her work in the schools was directed by the school superintendent exactly as tho she were a member of his staff. In other communities the activities were divided between school system and health department in many different ways, and yet programs of each type were found to go forward successfully where the professional leadership was good and sound principles of cooperation were followed.

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[1] This study was made by a committee of the American Public Health Association under the chairmanship of C. E Turner, with Philip L Riley acting as secretary and field investigator. The 120-page report may be secured by sending 9¢ in stamps to the American Public Health Association, 1790 Broadway, New York, New York

Examples of Coordinated Community Programs

Examples of coordinated community programs, mentioned below, are taken from the report of the American Public Health Association Committee on Community Organization for Health Education.

Bulloch County, Georgia—This southern county has a coordinated community program in health education which arose out of the curriculum revision program of the school system. The schools undertook to build a curriculum which would improve the life of the pupils. Among the conditions found to need improvement were health problems such as hookworm, smallpox, diphtheria, typhoid fever, tooth decay, and malnutrition.

For information on hookworm control they turned to the state department of health. When they came to consider the steps in the community which would be necessary for the treatment of children and the prevention of further soil pollution, they turned also to physicians for examinations, to the parent-teacher association for mobilizing public opinion, and to the WPA for a privy construction project. The community felt the need of a local health department, and one was established.

The county agent, the home demonstration agent, and the leaders of 4-H Clubs and of Future Farmers of America were brought into the program, as were teachers of vocational agriculture and home economics. By bringing together the school personnel, health department workers, and volunteer agencies in the community, a program has been set up to solve community problems and to provide cooperative planning for the future. This program has had striking results. Other examples could be given of counties which have developed coordinated programs of community health and health education upon the initiative of the school system.

Calhoun County, Michigan—This county is an example of rural health education which has been developed largely on the initiative of the health department. It is one of the counties in the Michigan Community Health Project which has been developed by the W. K. Kellogg Foundation "to bring to the communities through their own leaders the best of current thought in order that those directly concerned with the problems can work out their own answers. The challenge is to see whether local leadership so stimulated can develop really effective methods to meet community needs and thus advance the cause of child health, education and welfare over many fronts, local, state and national." [2] The program is built upon the philosophy that the health officer goes to the community not *with* a program but to *build* a health program in which he can furnish some aid in solving problems.

In the county there are twenty-five township committees, called "service committees," which are centers for civic betterment within the community. These committees assist in the program to prepare children for school attendance and they study community needs and seek the solution of community problems.

The health department has established cooperative relationships with the county schools in many ways. The first is the general program of services made available to the schools by the health department. At the annual meeting of all teachers, just before the opening of school in the fall, the county superintendent distributes to the teachers a bulletin which lists and describes briefly the sixteen services which they may expect from the health department. He also introduces the health department staff members to the teaching staff. One to two weeks later these staff members meet the teachers in smaller district groups and discuss with them the details of the program outlined in the bulletin distributed by the superintendent. Under this program the health department sponsors medical examinations performed by the private physicians of the community in their own offices and with the parents present at the examination.

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[2] American Public Health Association, Committee on Community Organization for Health Education *Community Organization for Health Education* Cambridge, Mass Technology Press, 1941 p 62.

The philosophy back of this program assumes that the responsibility for the health of the child rests upon the parent. Between the parent and family physician there should develop a program for the continuous health supervision of the child. The family physician should educate the parent, thru the technics of medical examination, immunization, and other health protective and remedial measures, to appreciate such services. The resulting satisfaction must be strong enough to make parents willing to pay for such services in the future. The family health counselor, who is trained in public health nursing, works with teachers and parents to help them see the benefits which will accrue to families from more medical supervision. An extensive and somewhat similar dental program is developed with the dental profession in the county.

Certain routine school health procedures are jointly planned and carried forward cooperatively:

1. Monthly weighing and semiannual measuring of all children by the teacher
2. Vision testing with Snellen chart of all children by the teacher as early in the school year as possible
3. Daily observation by the teacher of children's general health condition
4. Prompt exclusion from school of cases suspected of acute communicable disease
5. Periodic inspection of the physical facilities of the school to insure a safe and healthful school environment
6. Speech correction.

In these activities the family health counselor is of invaluable aid to the teacher. She instructs the teacher in the discovery of those signs which indicate that the child needs health service. The sanitarian (a sanitary inspector or a sanitary engineer) also contributes to the education and training of the teacher. These two assistants are available to teachers for consultation.

A hot lunch program is planned cooperatively with the WPA. A few schools now have their own gardens. Speakers are provided for meetings of school and community groups. The health officer acts as secretary of the schoolmasters club of the county. This club is composed of superintendents of the various school districts and meets monthly for the purpose of improving the educational program. Here the health officer and the school administrators work jointly in the solution of school health problems.

Teachers clubs, which are both professional and social in purpose, meet monthly. The family health counselors meet with these groups which consider health problems among the other problems of health education. A trained health educator works with the clubs and with the individual schools.

Washington County, Tennessee—An example of a rural area in which coordination in the field of education operates under the leadership of a health education coordinator is Washington County, Tennessee. The coordinator is employed by both the local school system and the county health department, acting with a subsidy from the state department of health and the state department of education. Thru her efforts, integration is secured between the health education program for the general public and the health education program in the schools. She is the supervisor of school health education and the director of public health education. Many agencies, such as parent-teacher associations and 4-H Clubs, cooperate in the solution of community health problems.

Hartford, Connecticut—An example of a medium-sized city which has worked out a cooperative, communitywide program of health education is Hartford, Connecticut. Here the medical and nursing services in the school are provided by the school system. The board of health, volunteer health groups, and the board of education work together in analyzing and meeting community needs. Upon the joint initiative of the board of health and the Hartford Tuberculosis and Public Health Society, sixteen agencies were brought together to organize a cooperating group. Later five other agencies were added.

Twelve districts were set up within the city. The districts were organized upon the basis of population characteristics, geographic location, morbidity, mortality, and such facilities as the distribution of settlement houses and clinics. The local steering committees for the respective districts usually consist of parent-teacher representatives, school doctors and nurses, school principals, school teachers (especially those from the fields of home economics and science), clergymen, community house representatives, social workers, and socially-minded citizens.

This cooperative social machinery operates thru the development of better educational methods by the schools themselves, thru the development of local community leaders by means of leaders' institutes, thru educational programs for the general public, thru investigations, and thru the study of local health problems.

Urban practices—Many of the larger cities, Cleveland, Ohio, for example, have secured an effective cooperation thru the organization of community health councils. All the agencies in the community have been brought together and each has indicated its field of work and its program. Helpful interrelationships have been set up. School personnel have had an opportunity to learn more about community facilities in the field of health. The school's program, its point of view, and its operation have become better understood by health agencies.

Principles of Community Coordination

Exhaustive discussion of individual programs, reflecting successful cooperation, is impossible within space limitations. It is possible to cite certain principles of coordination and to illustrate to some extent their application.

1. *Any plan of cooperation requires a delineation of the activities of the participating agencies and of the individuals within the agencies*—Each agency defines its field and clearly understood boundaries of these respective fields are set. If such steps are not taken, sufficient friction may develop to make the project unsuccessful. Usually, agency functions are better defined than member functions within the agency. In one community, for example, a health department nurse in the school was declared uncooperative because she refused to weigh children monthly. The teacher and the nurse were not at fault for their disagreement. The trouble lay in the failure of the administration to define the respective functions of these two workers.

2. *Any participating agency must retain administrative control of its own activities*—The coordination of army units does not mean that cavalry officers will issue orders to infantry troops or that navy commanders will change the program of the army air force. Every administrator recognizes that chaos is inevitable when conflicting directions come to the same individual.

Many school health administrators have emphasized the advantages of having school health services within the school system because, in that case, all school employees are under the same administrative head. On the other hand, eminently successful school programs may be cited in which the health services are administered by the health department. In these cases, there is a clear understanding of both the scope of activities and the respective sources of authority.

Everything which goes on in the schools must be in accordance with school administrative policies. There is no reasonable excuse for either the health department or the private agency to enter the schools with a program which runs counter to the educational policies of the school administration.

Sometimes a school nurse from the health department who teaches classes in the schools complains that supervision from the educational supervisor imposes unwarranted regulations upon her activities. Not at all! She should not be teaching, except in home nursing, unless she meets the same standards of teacher training as do other teachers, and in any case when she does teach she must, like all other teachers, accept the supervision which is provided. The matter is simpler and friction is less if all those who teach are members of the school staff.

When doctors and nurses are supplied by the health department, it is expected that medical and nursing technics will be decided by the health department. Professional technics should be decided by persons of that profession. When working in the schools, however, every individual should work in accordance with school policies and should be subject to the administrative organization of the school system.

3. *Cooperation in the school health program requires a recognition of the professional nature of education as well as that of the health-medical sciences*—Difficulty sometimes arises in separating the educational functions of physicians and the health functions of teachers. The physician provides health guidance for the individual child. This is, for the child and for his family, a highly educational experience. The teacher is concerned with health problems which do not need specific medical or dental attention. She deals with accepted standards of individual conduct or principles of health behavior. Most of her instruction involves groups of children, and for this type of program she is admirably trained.

It is true that the classroom teacher has a limited knowledge of health, but it is also true that the medical specialist has a limited knowledge of education. In matters regarding medical or dental supervision, a specialist should function; in matters of training for healthful living, that other trained specialist, the teacher, should function. Let cooperation bridge the gaps of preparation.

Good administration will allow the educational specialist and the health specialist to work together, each respecting the professional status, skill, and activities of the other.

4. *There is no single best plan for the coordination of agencies in the health program of the school*—Local factors and available personnel influence all plans. While the mechanism of coordination is of some importance, the people who operate it are more important. A good mechanical plan can succeed only when the people who operate it are broad enough to see its values, are compatible personally, and are not antagonistic professionally.

Successful coordinated programs are sometimes based upon informal personal relationships between the administrative heads of the cooperating agencies. They are sometimes based upon rather informal committee organization and sometimes upon the organization of a more formal health council.

5. *In successful joint programs the democratic process of group thinking is important*—Persons and organizations should subordinate their individual interests and desires to the more important purposes of the joint project Even tho some individuals and groups must play a more important part than others, a dominating attitude cannot be assumed if the program is to succeed. When a joint committee is formed for cooperative action, those agreeing to the plans set up must make no mental reservations about their agreement. Success comes from cooperation, and cooperation does not exist where an individual agrees verbally to support a project but privately works to build up his own organization to the detriment of the general plan.

6. *The development of community organization in a democratic society requires continued, patient, and persistent effort*—The democratic process is slow. It does not operate with the speed of dictatorship. It may, however, be more effective as well as infinitely richer in the satisfaction obtained by the free people who exercise it.

7. *As cooperative activities succeed and increase in scope, there often develops a program requiring the efforts of some one person to draw the activities together and to see that the program as a whole moves toward the general goal*—Sometimes this is done by an individual representing one of the participating agencies and with the endorsement of all the other groups. Sometimes a coordinator is employed for this specific task. The coordinator must be a person who does the same thing for all the agencies involved. His position should be such that he can properly represent the respective agencies in the field under consideration.

Relationships with State Agencies

Certain regulatory influences from outside the community may direct, circumscribe, or formulate the relationships between local agencies. The state law which defines the duties and responsibilities of health departments and school systems is one of these. Another factor is the distribution of federal funds thru state authorities. These funds make possible the extension of activities which are desirable but in excess of the financial resources of the community. Ideally, these funds should be available to whichever agency carries on the activity for which the funds are appropriated, and the coordination of agencies should be so good that existing personnel would be expanded and strengthened rather than dislocated and replaced. Actually, human nature is such that activities tend to grow in whatever hands hold the dollars.

There are outside forces from which assistance can be secured in developing coordination of activities. Several forms of cooperative planning are to be found between the state department of health and the state department of education in various states. Here, as in local communities, certain types of personnel in the field of school health are sometimes found in departments of health and sometimes in departments of education. At present, many state departments of health employ coordinators of health education whose services are mainly at the disposal of schools. Good relationships between state departments tend to further the coordination of local programs of school health and health education.

The state department of education should shape educational policy in the field of health as well as in other areas. Special help may be expected from it in shaping the health education curriculum. However, each school system will do well to plan its own teaching program even tho a general outline is provided by the state. The development of a health curriculum locally, thru carefully organized committees, surpasses all other procedures (a) in finding those local health problems which should be considered in the instructional program, (b) in educating the staff for better health teaching, and (c) in producing a readiness on the part of school personnel to carry forward the approved school program. Such curriculum development under the administrative leadership of the school superintendent and with the assistance of the best available expert in health education is one of the most important steps which can be taken for the promotion of community health.

State departments of health may be looked to as a source of information concerning health problems within the state, as a source of health policies, and to some extent as a source of supplemental teaching materials.

The state university and other institutions of higher learning are concerned with research which yields new facts. Upon these new facts better programs can be built. These institutions are also concerned with the improvement of educational method and in many cases with the provision of supplemental educational material.

Tennessee

Tennessee[3] is an example of cooperative relationships at the state level:

> Today the program in Tennessee has expanded beyond the sponsorship of the University State Health Department and Commonwealth Fund to include the State Department of Education, State Teacher Training Institutions, and the Tennessee Valley Authority. In 1935, these joint agencies set up a Planning Committee, composed of the executive heads of the most active agencies. This group meets from time to time to review programs and problems, and determine the next steps in development.
>
> This committee functions through an executive secretary and field representative known as the State Health Education Coordinator, employed in 1935 in the person of Dr Robert H White. He concerns himself with the inter-relationships of the cooperating agencies His second task is that of liaison officer between the planning committee and the field personnel, such as county school superintendents

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[3] The Tennessee program is described in the following: Walker, H. H. "A State-Wide Program in Health Education" *Southern Medical Journal* 32: 219-24; February 1939.

and health officers He . . . is jointly employed by all the cooperating agencies and is a staff member of each.

The essential parts of the Tennessee program are:

1. On the part of the University
   a. Minimal preparation for all elementary teachers in the field of health education.
   b. More intensive training for those who wish to specialize in health education.
   c. Graduate training for professional health educators, coordinators and supervisors.
   d Consultant, planning and field advisory service to any state or local agency requesting such a relationship.
2. On the part of the State Health Department.
   a. Financial aid to University and State Teachers Colleges for faculty salaries. Travel funds and contingent grants have been contributed to certain of these institutions.
   b. Scholarships for graduate training and for selected in-service teachers.
   c. Furnishing free pamphlets and literature to schools.
   d Publication of over 15,000 "Health Briefs" monthly for teachers in the state.
   e. Financial aid to local coordination programs.
3 On the part of the State Department of Education.
   a. Bulletins to teachers on methods, units and projects for improvement of classroom instruction.
   b. Collaboration with State Health Department on Score Sheet for sanitary inspection of schools, and interpretive manual for aiding pupil-teacher studies in sanitary living.
   c. Selection of personnel for graduate training in health education.
   d. Incorporation of sanitation and health program standards in new grading classification for all schools. (Prepared in collaboration with the State Health Department.)
   e. Financial aid to local health education programs.
4 On the part of the Tennessee Valley Authority.
   a. Technical and educational consultation service to state and local agencies
   b. Staff contributions to teacher-training programs.
   c. Financial assistance to inter-agency coordination.
5. On the part of counties.
   a. The planning and development of local programs using health coordinators.[4]

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[4] American Public Health Association, Committee on Community Organization for Health Education *op. cit.*, p. 106-107.

Oregon

Oregon's state program[5] arose from the requests of the associations of city and county superintendents of schools:

> These groups sought the aid of the State Department of Education and State Department of Health in outlining a uniform health program for city and county schools. This demand showed a need for clarifying the state functions and relationships in health and education, hence the joint committee.
>
> Three sub-committees of the State Joint Committee, called Working Committees, were developed; namely, Health Education, Physical Education, and Recreation.
>
> The members of these committees are local school superintendents, school teachers, doctors, health officers, nurses, and custodians. These people in the actual field of operation meet and prepare definitions of function and statements of proper relationships between groups of personnel.
>
> These statements of policy are then submitted to the State Joint Committee for approval or recommendation. The State Joint Committee, if it accepts the report of the working committees, thus builds a state policy based upon actual field work, and not upon bureaucratic decisions emanating from sources remote from actual problems.
>
> It is hoped that by this procedure there will eventually develop a statement of principles for the guidance of schools, health departments and community agencies that will serve as a pattern for communities in the state. This pattern having had the stamp of approval of the Joint Committee can be urged alike by health and school officials Since the fall of 1939 and the spring of 1940 saw the first efforts of the working sub-committee in health education, this program is still in its early stages Nevertheless, it is already influencing health education in two cities which are the laboratories where the policies of the Joint Committee are developed[6]

The specific functions of the State Joint Committee are:

A. Policy Forming Body

1. Determine governmental responsibility, defined by law, of the three State official agencies
2. Determine individual and group responsibilities of the three State official agencies with respect to Education for Health in the schools of Oregon,
3. Determine policies and terminology with reference to Education for Health.

B. Clearing House Body.

1. Consider and coordinate various committee and group recommendations as they are concerned with and affect the schools

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[5] Information concerning the Oregon program may be secured from the Oregon State Department of Health

[6] American Public Health Association, Committee on Community Organization for Health Education, *op cit*, p 109-10

2. Consider various activities affecting the total health program which non-official groups may wish to carry on in the schools.

C Administering Body.

1. Determine the kinds of working committees necessary to carry forward the purposes of the Joint Committee
2. Select and appoint personnel on the Working Committees
3. Prepare, or accept, jointly, certain materials for recommendation to the State Department for joint publication[7]

Relationships with National Agencies

In the past decade school administrators have become increasingly aware of the existence of many national agencies in the field of health. The federal government has been particularly active under the various types of social legislation such as relief, social security, and public health.[8] Many of these activities have reached the local community thru the departments of state government. This contact has not always been indirect, particularly in the case of the NYA, CCC, and other programs which have sometimes been associated with the local school program. Contacts may become increasingly direct as various aspects of the defense program develop.

Representative National Agencies

Most national agencies interested in health education may be classified either as those of the federal government or as private interests. The present section will touch briefly upon those of most interest to educators. Further details on the services of national agencies are given in the Appendix of this yearbook.

U. S. Office of Education—In the field of health education the Office is primarily a clearing-house of information. It prepares articles for its official magazine, *School Life*, and issues bulletins of interest to school administrators, such as *Organization and Administration of School Health Work*.[9] Many letters of inquiry are answered and, when expenses are paid by the local school system, some field work is made available.

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[7] American Public Health Association, Committee on Community Organization for Health Education, *op cit*, p 108

[8] The comprehensive character of the federal government's plans is indicated by the following bulletin Interdepartmental Committee to Coordinate Health and Welfare Activities *The Nation's Health*. Washington, D. C. Government Printing Office, 1939 116 p

[9] Moore, Fred, and Studebaker, John W. *Organization and Administration of School Health Work* Federal Security Agency, U S. Office of Education, Bulletin 1939, No. 12 Washington, D C · Government Printing Office, 1940 67 p

National Youth Administration—This unit has launched a nationwide health program to serve the needs of young workers who are employed on its out-of-school work program. This effort to afford young people the experience of practical health education in order to help strengthen the nation's vital defenses by building a strong and healthy population will be directed along three major lines:

1. A physical appraisal, by means of a technically competent health examination, of every youth assigned to an NYA job
2. Correction of health defects thru maximum utilization of community resources, thru the use of supplementary medical and dental services provided where possible by the NYA, and thru developing in youth an interest in improving their health by their own personal efforts
3. Improved technical advice and assistance with respect to all NYA efforts having a direct and immediate bearing on the health of youth workers, such as nutrition, sanitation, physical development, and recreation.

The NYA health program is primarily a practical health education effort aimed at influencing the future health practices of a group of young out-of-school unemployed persons, who will usually remain in NYA employment for only a short period.

The method of attempting to accomplish this purpose will be thru imparting health information, acquainting and introducing the young people to the public and private health facilities available in their own state and community, and finally by exposing them to rehabilitative health services obtainable from the private practitioner either on the youth's own initiative or thru NYA supplementation as may be indicated.[10]

Children's Bureau—The federal grants-in-aid for maternal and child health services authorized under the provisions of the Social Security Act are administered by the Children's Bureau. These grants are made only to the official state health agencies in accordance with provisions of the Act. The Children's Bureau cannot grant to local school systems any of the funds appropriated under Title V, Part 1, of the Social Security Act. The planning of the expenditure of these funds in any state is made by the official state health agency. There is usually close cooperation between the official health and education agencies in developing health services for school children.

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[10] Adapted from "The National Youth Administration Contributes to the National Health" *Journal of the American Medical Association* 115: 2185-86, December 21, 1940. ¶Information obtained from the Washington office of the National Youth Administration, May 1941

Many of the state health agencies use a portion of their maternal and child health funds for developing school health services.

The Children's Bureau has not prepared an outline to be followed by the state health agency in developing their school health programs since the health problems differ considerably thruout the country and the responsibility for the administration of various aspects of the school health program differs considerably between states and local areas.[11]

U. S. Public Health Service—Under the provisions of Title VI of the Social Security Act, grants-in-aid for public health services are allotted to the several state health departments. Altho the funds appropriated under this title are administered by the Public Health Service, the expenditure of such funds is under the direct jurisdiction of the state health departments. Therefore, if Title VI funds were made available to school systems for an activity such as health education, it would necessarily be thru the state health officer.

Upon the request of the state health officers, the Public Health Service renders expert consultative and advisory services to the state health departments relative to the various phases of public health. Such services could be given to the larger school systems upon the recommendation by the state health officer that this would be desirable. In November 1941 the Public Health Service announced plans to appoint health education consultants to work with state, county, and local health officials in coping with health problems arising from the defense program.

Title VI funds may be used by the state health departments to finance the public health training for various personnel. In some instances, upon recommendation by the state health officer, teachers have been given this aid.[12]

Social Security Board—There are no funds granted directly to local school systems. Indirect aid to schools thru aid to individual pupils or teachers, provided by the social security laws, are as follows (the first three types of grants are made thru the Social Security Board):

1. Every child of an individual entitled to primary insurance benefits or of an individual who died a fully and currently insured individual will receive com-

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[11] Adapted from information supplied by the Children's Bureau, U S Department of Labor, May 1941

[12] Adapted from information supplied by the U. S. Public Health Service, Federal Security Agency, May 1941.

pensation It is further provided, however, that a child of sixteen years of age but under eighteen must attend school to receive compensation. A child is defined as a real child of an individual or a stepchild of an individual by marriage contracted prior to the date upon which he attained the age of sixty years and prior to the beginning of the twelfth month before the month in which he died, or legally adopted by an individual prior to the date upon which he attained the age of sixty years or the twelfth month prior to the month in which he died. A child is a person less than eighteen years of age.

2. Dependent children shall also receive aid. A dependent child is defined as a needy child under the age of sixteen years or under the age of eighteen years if found to be regularly attending school, who has been deprived of parental support and care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent; or who is living with his father, mother, grandfather, grandmother, brother, sister, step-father, step-mother, step-brother, step-sister, uncle, or aunt.

3. Crippled children shall receive aid thru diagnosis, hospitalization, and after-care.

4. Aid to develop local child welfare services in areas predominantly rural. This aid is furnished thru the Children's Bureau of the Labor Department.

5. Aid in the training of personnel for state and local health work. This aid is to be furnished thru the United States Public Health Service.[13]

Farm Security Administration—No grants of money are made by the Farm Security Administration to school districts for health purposes. As an indirect result of the Farm Security Administration medical care program, however, the health problems of many school districts have been somewhat lessened. Most of the low-income families who are taking part in the various health service plans have children of school age. These children are being put into fit physical shape and are being given medical care which they otherwise would either have gone without or would have had to depend upon local institutions to provide.

Under a typical medical care plan, all the FSA borrowers in the county who wish to participate pay a fixed sum each year for medical care. For the first year, this sum usually is included in the rehabilitation loan. These payments are pooled, in the hands of the county trustee, to serve as a kind of voluntary health insurance system. If a member of the family becomes ill, he may go for treatment to any doctor in the county who is taking part in the plan. All the doctors submit their bills at the end of each month to the trustee for payment.

Benefits covered in the plan usually include: (a) ordinary medical care, including examination, diagnosis, and treatment in the home or in the office of the physician; (b) obstetrical care; (c) ordinary drugs; (d) emergency surgery; and (e) emergency hospitalization. Some counties have added dental services either as a part of the regular medical care program or under a separate plan.

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[13] Adapted from information supplied by the Social Security Board in cooperation with the U. S. Office of Education, Federal Security Agency, May 1941.

There are other ways, of course, in which assistance to farm families by the Farm Security Administration indirectly contributes to better health conditions among school children. The emphasis on home-produced food and home management supervision are improving nutrition among low-income farm families and providing adequate balanced diets for the children.[14]

Work Projects Administration—Direct grants of money are not made, but local and state school systems are assisted in conducting their own health programs thru activities such as the following:

1. General physical examinations of school children
2. Special examining or testing programs
   a. Hearing
   b. Vision
   c. Tuberculosis
3. School dental examinations and services
4 Immunization of school children
5. Examination of preschool children within the year before they enter school
6. Clerical activity incidental to school health programs
7 Special surveys and research on health problems to assemble data for administrative use.

If a health project desired by a particular school system requires a sufficiently large number of certified workers, a professional or technical person or persons can be included on the project payroll to furnish supervision. If the project is not large, all technical direction must be furnished by the sponsor except where provision can be made to employ noncertified supervisory individuals at the security rate of pay.

The WPA does not attempt to name the health activities in which the school system should engage, altho at the present time, because of the limited quotas of WPA workers, it would seem advisable to place emphasis upon the more direct services to school children, such as immunization and vision and hearing testing programs, rather than upon such activities as preparation of health education pamphlets and posters. Where a school superintendent desires specific information regarding possible WPA project assistance in his health program, he should confer with his local or state WPA office.[15]

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[14] Adapted from information supplied by the Farm Security Administration, U. S. Department of Agriculture, June 1941.

Private national agencies—The number of private national agencies in the field of health is too large for presentation at this point. Widely known organizations include the American Medical Association, American Dental Association, National Tuberculosis Association, American National Red Cross, and the American Association for Health, Physical Education, and Recreation. The services of these and many others are given in the Appendix of this yearbook.

An agency which brings together all the national groups interested in the school health education field is the National Conference for Cooperation in School Health Education.[16] This is not a separate association or a "superorganization" but merely a clearing-house for mutual information, cooperation, and discussion in the improvement of material and methods and in the furtherance of school health education.

Principles Governing National Relationships

Since public education is a state function, administered usually thru local districts, there are several principles which need to be kept in mind:

1. In most instances the national agencies prefer that local school administrators should make contacts directly with the local or state representatives of the organization.
2. Financial grants by national agencies should be distributed thru the proper and regularly established state agency. There should be local autonomy in the use of these funds in terms of the needs of each community.
3. When it is necessary for national agencies to organize local projects, the activities initiated and the personnel assigned should meet the local and state standards prescribed for similar work.
4. It is a needless waste of funds and effort for national agencies to establish community projects which duplicate established local activities.
5. All instructional materials and teaching aids supplied by national agencies should be distributed with the understanding that they will be utilized and adapted in accordance with local educational policies.

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[15] Adapted from information supplied by the Work Projects Administration, Federal Works Agency, July 1941

[16] The secretary is N. P. Neilson of the American Association for Health, Physical Education, and Recreation, a department of the National Education Association, 1201 Sixteenth Street, N. W., Washington, D C.

Effectiveness thru Cooperation

It is now recognized that, even with an adequate program of sanitation, immunization, and law enforcement, the community cannot achieve its maximum health without a thorogoing program of health education. Such a program should touch each segment of the community, in accordance with its nature and needs. It should deal intelligently with actual and existing problems, distributing emphasis according to importance and urgency.

It would seem logical, therefore, for school systems, health departments, and private agencies to work together in finding such problems and in moving toward their solution. In reality, we find that steps toward better community organization for health education have appeared independently and spontaneously in many widely separated communities.

Some of the weaknesses of a program which is not based on community planning are immediately apparent. Such a program is likely to be one of special interests, in which neither the differing needs of various areas within the community nor the requirements for different educational methods are recognized. The topics included in such a program will be those represented by the interests of individuals or small groups instead of those topics which should emerge from a study of the whole community. Thus there is danger that the educational program may be one of "teaching, from the top down" rather than one of "learning, from the bottom up." After all, education is learning, problem-solving, and growth on the part of the individual to be educated rather than the oral or written presentation of information by the educator.

It is a sound, democratic, self-reliant procedure for a group of people, with the help of specially qualified leaders, to find their own health problems and to seek the needed information thru which they can solve these problems. Those who expect the government to do everything for them complain of its inadequacies and look for its imperfections. This develops disrespect for democracy and actually weakens it. The group which starts to solve its own problems learns to appreciate the assistance which governmental and social agencies can give. This develops understanding of the democratic process and strengthens it.

CHAPTER XVI

Legislative and Legal Aspects of the School Health Program

IN THE CONSIDERATION of the legislative aspects of a program of health education, we are immediately confronted by at least three fields of research. The first deals with the historical background out of which modern methods in sanitation and health education have developed. The second is to be found in the consideration of current best practice in school sanitation and hygiene as determined by law. The third deals with modern trends in the teaching of health and the establishment of hygienic controls.

Historical Background

Anthropologists have contributed much in support of the fact that attempts to control the inroads of disease have grown up out of the mores of the members of any given social group, be it primitive or modern. Morrison [1] calls attention to the fact that the study of civilization leads to the discovery of early folkways and taboos that have a sanitary import. Similar deductions have been made by Breasted [2] in investigations going back further than 3000 B.C. While many of the early health codes were built around superstitions and ritualistic practices, Browne [3] has pointed to the fact that out of these have been developed the medicine man, the priest, religion, and science—all the result of man's attempt to adjust himself to his environment. The Code of Hammurabi was issued approximately 4000 years ago and was the basis for many subsequent similar codes to control health conditions for the protection of ancient peoples. Tobey [4] has called attention to the fact that both Plato and Aristotle advanced the opinion that "no city should exist without health officers." On down thru the Middle Ages, when pestilence and plague decimated the populations of cities and rural areas, quarantine and sanitary ordinances were adopted to protect the people.

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[1] Morrison, Henry C. *The Curriculum of the Common School.* Chicago: University of Chicago Press, 1940. 681 p.

[2] Breasted, James H. *The Dawn of Conscience.* New York: Charles Scribner's Sons, 1934. 431 p.

[3] Browne, Lewis. *This Believing World.* New York: Macmillan Co., 1930. 347 p.

[4] Tobey, James A. *Public Health Law.* New York: Commonwealth Fund, 1939. 414 p.

Health regulations in the American Colonies date back to 1647, when action was taken by the General Court of the Massachusetts Bay Colony to quarantine against the spread of yellow fever. Tobey[5] traces the procedures taken thru legislative action to control epidemic conditions and provide for health protection. In 1793 the first local board of health was founded in Baltimore, and by 1909 legislation for the protection of health had been generally adopted in all states of the Union.

Sanitation in the Pioneer School

As the population moved westward, health and sanitary conditions continued to reflect the mores of the people. Pioneer school buildings were similar to the dwellings of the early settler. They were of log construction with benches made of log slabs arranged around the sides of the room, facing the crude shelf that was fastened to the wall and designed to serve as a desk for writing. A striking description of sanitation in the pioneer school has been given by Kennedy and Harlow in the following statement:

> Of course the old fireplace had disappeared, and the school heating plant now consisted of a cast-iron stove set in the center of the room, with a long pipe shooting up to a right-angled elbow, and then tottering over to the chimney hole in the wall, supported by wires suspended from the ceiling. On very cold days, the pupils sitting nearest the roaring stove were red and sweating, while those near the windows might be blowing on their fingers.
>
> Itch and lice were still afflicting country schools in my youth. There was an outbreak of itch every winter when the pupils came together, for some scrub families had it the year round and distributed it among others as soon as school opened—whence arose the legend of the "seven-year-itch." It could be cured at any time with an ointment of grease and sulphur—or other things—which killed the tiny mites that caused it; but some families were too ignorant or dumb or lazy—or all three—to do even this. Neither of these pests was any respecter of persons; the careful and cleanly must be always fighting them off in the country. You clasped hands or scuffled with a boy who had the itch, and first thing you knew, there you were with a case, too—sometimes just from sitting in the seat with him.
>
> Itch raged among medieval royalty and aristocrats, and that Grand Monarque, Louis XIV, had lice under his wig. But long before his time it was known that lice were the particular guests of dirty people; an old English commentator was of the opinion that the louse "commeth out of the filthi and oncleane skynne," and as Louis was one of the dirtiest of kings—one of his courtiers said that he "smelt like a carcase"—it is no wonder that he was verminous. The soldiers came home from the Civil War with all three kinds of lice; and as there were no de-

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[5] Tobey, James A., *op. cit.*, p. 11-15.

> lousing rites then, as after the World War, and as some of the soldiers were not very particular, anyhow, it took years to undo the backset which they gave us
>
> In our neighborhood, as in most others, it was only a small minority of families who kept these pests alive and regularly handed them around to the rest of us. One could plainly see the white louse eggs or nits on the unkempt hair of such folk, especially if the hair was dark There was nothing that could be done about it; compulsory sanitation had not yet come into style. They were freeborn American citizens, by gosh, and they had as good a right to tote lice around as they had to breathe the ozone. But my mother and others of her fastidious kind used to grumble aloud the wish that it were possible for someone to grab those young 'uns and stick their heads into a pail of lye water so strong that it would take the hair off. I had to undergo an inspection—an occasional treatment—every three or four days, with my head clamped between Mother's knees if I was disposed to be too restless. There were times when the pests were particularly active, when she kept my hair cut so short that I looked like a peeled onion.[6]

The progress made in the improvement of sanitary conditions and health education was slow. Superstitions prevailed and still prevail as has been shown by Elizabeth Bowman,[7] who mentions luck in finding a horseshoe, wearing a piece of lead around the neck to stop a nosebleed, wearing a match in the hair to cure headache, carrying a buckeye or shriveled potato to cure rheumatism, together with a score of cures for warts, still accepted by many persons dwelling in the southern highlands and other sections of the United States.

Basic Concepts in School Health Legislation

As educational opportunities were extended and the findings of science were made available, the citizens of the United States became aware of values to be found in following the established laws of health. Practices and procedures in healthful living that were beneficial for the individual were declared to be beneficial for all. It was soon found that the practice of laissez-faire could not be accepted in sanitation and health education in the schools of the nation. Gradually laws were written to safeguard the health of the children and lay the foundation for an appreciation of health as the foundation of success and happiness.

The laws governing sanitation and health education in the schools of the United States are to be found (a) as provisions in both federal and state constitutions, (b) in statutes enacted as laws by state legislatures, (c) in municipal legislation in the form of ordinances, (d) in provisions contained in special charters granted to municipalities by state legislatures, (e) in regulations adopted by state boards of health, and (f) in case law handed down in court decisions based upon statutory and upon common law. From these sources there has resulted an extensive body of law which covers nearly all phases of health education and healthful living.

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[6] Kennedy, Millard F , and Harlow, Alvin F. *Schoolmaster of Yesterday* New York McGraw-Hill Book Co , 1940 p. 217-19 Quoted by permission of the publisher.

[7] Bowman, Elizabeth S. *Land of High Horizons* Kingsport, Tenn.: Southern Publishers, 1938 212 p

Statutory provisions and court decisions have confirmed the right of schoolboards and school directors to purchase school sites, erect school buildings, issue bonds, and enter into contractual relations for the accomplishment of the desired ends. The steps taken by the school authorities are designated by laws, ordinances, and building codes designed to insure the proper performance of contracts and safeguard the interests of the public.

It was not until the beginning of the nineteenth century that attention was given to the architectural features of school buildings. Russell and Judd[8] have traced schoolhouse construction from the one-room, box type of school building to the modern, carefully designed structure that meets all the demands for safety and hygiene.

Building Codes

In making designs and drawing specifications for school buildings, architects have been guided in the consideration of health problems by building codes adopted by state and municipal authorities. These codes have been drawn by commissions made up of legislators, engineers, and in some instances educationists and experts in the field of public health. The enforcement of specifications contained in building codes has resulted in a definite improvement in the design and construction of school buildings from the standpoints of both safety and health. Efficient school administration demands a full and complete knowledge of state and municipal building codes. This trend in administrative practices as an emphasis in health education is developed more fully in Chapter XII of the present yearbook.

Powers Vested in Schoolboards

The legal control of the public schools of the United States is, for the most part, vested in the state legislatures. The federal government controls educational activities in the District of Columbia, on government military reservations, and in areas occupied by Indians or not yet admitted into statehood. West Point Military Academy and the Naval Academy at Annapolis are under the direct supervision of the federal government. The legal status of the public schools has been clearly defined by Edwards [9] as being under the direction of local boards of education deriving their power from laws enacted by state legislatures. Thus the state legislature is primarily a board of education delegating powers to local and state officers who are responsible for administration and supervision in the various districts of the state.

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[8] Russell, John D., and Judd, Charles H. *The American Educational System* Boston: Houghton Mifflin Co., 1940 554 p.

The authority to manage and direct the health work in the public schools of the states has, for the most part, been vested in the local school districts under the supervision of state boards of health according to legislative enactments. Boards of education may, in turn, adopt rules and regulations to cover the specific needs of a given situation. These may include the adoption of rules to insure proper sanitation of schoolhouses and school premises; the provision of health, nursing, and dental inspection of the pupils; the adoption of a program of physical education; and the reorganization of the curriculum to include subjects designed to promote a knowledge of the principles of healthful living. Thus legislation in support of health education has received increasing attention since the turn of the century. In 1892 the Ohio legislature authorized a statewide program of physical education. In 1899 Connecticut took the first step authorizing health guidance in the schools. In 1906 Massachusetts adopted legislation making health guidance mandatory in all cities and towns of the state. Other states have adopted laws, similar in form, during the succeeding years.

Administrative Controls of School Health Activities

Health education in the schools may be considered under two types of activity. The first is that of instruction thru the courses of the curriculum. The second is to be found in health guidance and health protection.

The administration of school health activities differs in the several states. In certain instances the direction of the work is vested by law

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[9] Edwards, Newton. *The Courts and the Public Schools* Chicago University of Chicago Press, 1933. 591 p

HEALTHY MINDS IN HEALTHY BODIES—*At one time, education was concerned only with training the mind. The modern school attempts to send forth graduates who are both physically and mentally prepared to cope with adult responsibilities. Democracy needs not only trained minds—but also healthy minds in healthy bodies.*

Photograph by
Pittsburgh (Pennsylvania) Public Schools

entirely in the board of education. In other states it is in the hands of the board of health. There are situations in which there is a division of authority upon a cooperative basis. Hiscock [10] has pointed out, in a report of the Committee on Administrative Practice of the American Public Health Association, the desirability of a separate and distinct division of the health department, in cities having a population of 100,000 or more, to direct and supervise the health program in the schools. The report points out the advantages and the disadvantages to be found in the administration of the health program by the school authorities or by the municipal department of health. An integrated, cooperative program is deemed most desirable in the interests of efficiency.

Curriculum Organization

The contribution of curriculum organization to health education, according to Morrison,[11] may be attributed to (a) the reading capacity of the masses, (b) the intelligence resulting from more than two generations of effective science teaching, and (c) the persistent emphasis upon the teaching of hygiene.

That the introduction of physiology and hygiene as common school subjects was not easily accomplished has been frequently recorded in various accounts from the history of American education. A graphic statement of the attitude of pioneer communities is given in the citation from Kennedy and Harlow presented herewith:

> It was in my early teens that physiology, the last of the eight subjects which thereafter made up the common, that is, the grammar-school curriculum—the other seven were reading, writing, spelling, arithmetic, grammar, geography and American history—began to appear timidly in our rural schools. It had been used in higher education long before that There were textbooks—Calvin Cutter's *Anatomy, Physiology and Hygiene, Designed for Colleges, Academies and Families*, for example, published in 1852; and I have seen a copy used by a student in a young ladies' seminary in Kentucky—her autograph is still there on the flyleaf, with the date, "May 7, 1856," which should prove that our cultured young women of eighty and ninety years ago were not reared entirely on prunes-and-prisms, as the legend-mongers of today would have you believe.
>
> This book contains errors, it is true, but present-day readers would do well to look over it and discover how much our great-grandparents knew about the body, after all. For example, it explodes the myth that in those days sickrooms were invariably kept tightly closed. On page 434, under "Care of the sick," it says,

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[10] Hiscock, I V, editor. *Community Health Organization* New York Commonwealth Fund, 1939 318 p

[11] Morrison, Henry C, *op. cit*, p 641

> "It is the duty of the nurse to see that not only the room is well ventilated in the morning, but that fresh air is constantly admitted during the day." . . .
>
> But in 1874 a new book, Dr. J. C. Dalton's, came out, which included hygiene and which pictured the human machinery in a much more attractive aspect. It began to be used in rural schools, but there it often found the progress of thought from ten to twenty years behind that of the towns, meeting opposition on the part of some parents, who thought the study rather indelicate, and particularly unsuited to girls and young women. Even after I began teaching in 1883, there were mothers who asked me if I thought the teaching of physiology was necessary. Bill Nye wrote one of his best pieces around 1885, a supposed oration of a self-made man at a rustic Fourth of July celebration, in the course of which he said:
>
> "I tell you that the seeds of vice and wickedness are often sowed at school in the minds of the young by teachers who are paid a large salary to do far different What do you think of a man who would open a school with prayer and then converse freely about the alimentary canal? Such a man would lead a life of the deepest infamy if he had the least encouragement.
>
> "Last winter we paid thirty-four dollars per month to a man who opened the school with prayer and then made a picture of the digestive organs on the blackboard And yet we wonder that politics is corrupt."
>
> Making all due allowances for Bill's comic overstressing, those lines still have a background of fact; that was precisely how some hidebound rustic minds regarded the subject. But reason and common sense prevailed over this minority, really rather rapidly, as we see it now, and the study of the body became an unquestioned pillar of education[12]

With the general acceptance of anatomy, physiology, and hygiene as subjects to be included in the curriculum of the public schools, the demand for other subjects increased. By 1880 pressure groups had succeeded in passing laws in every state in the Union making the teaching of the physiological effects of alcohol and narcotics mandatory. At this time the new emphasis of instruction was upon healthful living and hygiene.

The mandatory requirements in the selection and presentation of subjectmatter in the curriculum have resulted in the challenge of the authority of boards of education to compel pupils to pursue certain subjects. In the decisions rendered the courts have been divided. In one decision[13] it was held that since the state can compel a child to attend school it also has the right to demand the study of prescribed subjects. Other decisions held to the view that parents have a right to select certain studies to be pursued by their children, providing the selection is reasonable and does not interfere with the management of the school.[14] Edwards [15] holds to the view that there seems to be little doubt but that the state possesses the authority to require pupils to pursue subjects prescribed in the curriculum.

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[12] Kennedy, Millard F., and Harlow, Alvin F., *op. cit* , p 223-25 Quoted by permission of the publisher

[13] *People v. Stanley, 255 Pac. 610.*

A supreme court decision [16] from the state of Colorado holds to the point of view that a board of education cannot require pupils to pursue courses "not essential to good citizenship," thus injecting into curriculum organization a definite criterion in the selection of subjectmatter.

In general the school statutes hold to the position that the common "public schools are established for instruction in the branches of education for which the teachers are qualified and such other branches as the directors or board members may designate. In some states the voters of the district may determine at a school election the courses to be offered in the curriculum of the school." German, French, Latin, domestic science, agriculture, botany, and other useful subjects are included within the term "branches of education" and these may be taught in high school upon the recommendation of the board of education.[17] As a result of this ruling, courses in physiology, anatomy, hygiene, physical education, and a wide range of subjects have been adopted as courses offered in the curriculum of the common school.

Legislation on School Attendance and Health Inspection

A major regulation in the establishment of satisfactory health conditions is found in the power of schoolboards to regulate school attendance. The courts have held that while all children have the right to attend school, the board of education may establish reasonable rules governing dress,[18] personal appearance, and physical condition. Pupils who are suffering, or appear to be suffering, from a communicable disease may menace the well-being of all pupils and therefore should be denied the privilege of school attendance.[19]

In assuming the responsibility for maintaining good health conditions, the courts have held to the opinion that schoolboards may enforce reasonable rules relative to a system of health inspection[20] and physical examinations.[21] In health inspection and physical examinations school authorities and the courts agree that clinical care and medical treatment are not within the legal authority of school-boards.[22]

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[14] Morrow v Wood, 35 Wis 59. ¶Rulison v Post, 79 Ill. 567. ¶Trustees of Schools v People, 87 Ill 303.

[15] Edwards, Newton, *op. cit.*, p. 555.

[16] People v Stanley, 81 Colo. 276

[17] School Law (Ill), Sec. 179

[18] Stromberg v. French, 60 N. D. 750. ¶Pugsley v. Sellmeyer, 158 Ark 247.

[19] Stone v. Probst, 165 Minn. 361. ¶Carr v. Inhabitants of Dighton, 229 Mass 304. ¶Martin v Craig, 42 N D 213

Immunization—It is generally known that certain diseases may be controlled by specific inoculation with scientifically prepared preventive substances. Such treatment has become common in the control of diphtheria, typhoid fever, smallpox, tetanus, and whooping cough.

The right of school authorities to demand compulsory immunization of children attending school has been repeatedly challenged by parents and various organizations. Most of the court decisions have been concerned with vaccination for the prevention of smallpox. There have been nearly a hundred court decisions involving some twenty states as well as the federal government, in which rulings have been handed down relative to vaccination. The controversy has continued for more than one hundred years, the first case being that of Hazen v. Strong[23] in 1830. A ruling of the Supreme Court of the United States[24] in 1904 upheld the authority of the state to enact laws making vaccination compulsory. Decisions handed down by state courts vary on some minor points, but in the main the police power of the state is upheld. Edwards[25] holds to the opinion that under the police power a state may require that all persons shall be vaccinated, and that such requirement is not "unreasonable, arbitrary, or oppressive" if, in the opinion of public health officers, the measure is necessary to guard public health and safety.

Under the legal provisions of most states the right of school authorities to exclude pupils from the schools, when not successfully vaccinated, is dependent upon the existence of epidemic conditions as determined by the state board of health. When such conditions are declared to exist, boards of education may make vaccination a condition for school attendance.[26] In dealing with cases involving immunization, much depends upon the existence of supporting statutory authority established by action of the state legislature. The general principle of reasonable demands by the school authorities is frequently mentioned in decisions handed down by the courts. Tobey definitely states that "school authorities, either acting upon their own volition or on order of the public health authorities, may exclude from school any child who is suffering from a communicable disease, a suspected disease, or any other mental or physical condition that causes the child to be dangerous or offensive to others." [27]

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[20] City of Dallas v Mosely, 286 S W. (Tex) 497. ¶Hallett v. Post Printing and Publishing Company, 68 Colo 573 ¶State v Brown, 112 Minn 370

[21] Streich v. Board of Education, 34 S C 169.

[22] McGilvra v Seattle School District No 1, 113 Wash 619

[23] Hazen v Strong, 2 Vt 427

[24] Jacobson v Commonwealth of Massachusetts, 197 U. S 11.

[25] Edwards, Newton, *op cit*, p 536-49.

[26] Hagler v Larner, 284 Ill 547. ¶Glover v Board of Education, 14 S D 139 ¶Zucht v San Antonio School Board, 170 S. W 840 (Tex)

Health inspection—In order to insure proper working conditions and health protection, boards of education have been sustained by court decisions and legislation to maintain supervision of health and sanitary conditions in the schools. This includes provisions for maintaining proper sanitary conditions on school premises and within school buildings, the establishment of a program of health education and physical training for all pupils, routine examinations to determine the physical condition of pupils and teachers, and the provision of adequate nursing service and medical inspection. All states in the Union have enacted legislation, more or less modified in form, to include many or all the functions listed.[28] In some states the powers of inspection delegated to boards of education are definite and direct. In others, the statutes are less effective. An example is presented herewith from the Illinois School Statutes:

> The board of school directors shall be clothed with the following powers. . . . *Twenty-first*—To establish and maintain a properly equipped first-aid room, with a competent nurse in charge thereof, in any school in which the said board deems it necessary, to assist the children of such school in case they are sick or injured. The assistance shall be rendered only at the school, and the nurse shall not interfere with the children in their homes, nor shall said nurse attempt to render assistance to, or in any way interfere with, any child or children, either at school or elsewhere, without the consent of said child or children and the teacher immediately in charge of said child or children, or over the objection thereto of the parent or parents, or guardian or guardians, of said child or children *Twenty-second*—To employ a physician and surgeon and define his duties.[29]

Because of the fear of enacting legislation that may interfere with the Bill of Rights, the Illinois statute does not in fact protect the children from the spread of contagion because of limitation upon inspection and assistance. However, where the schoolboards have been given legal authority to establish rules and regulations for the protection of pupils enrolled in the schools, close cooperation may be established between the state and local health departments, thus affording some protection under the general public health laws of the state.

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[27] Tobey, James A , *op. cit* , p 251

[28] Rogers, James F *State-Wide Trends in School Hygiene and Physical Education.* U. S Dept of the Interior, Office of Education, Pamphlet No. 5 Washington, D. C · Government Printing Office, 1934 15 p Also revised edition of 1941

[29] *School Law of Illinois.* Circular No. 308 As amended by Sixty-First General Assembly, 1939. Sec. 115, p. 7.

General administrative control of school health—The general administrative control of health in the forty-eight states is found in boards of health—federal, state, and local. The duties of these various boards have been stated in a bulletin issued by the United States Public Health Service.[30] Federal control is extended over ports of entry, government reservations, and situations demanding a defense of national interests.

The duties of state health departments as defined by Tobey are as follows:

1. To enforce and supervise the enforcement of all state health laws and regulations.
2. To prepare and issue reasonable regulations for the prevention and control of communicable diseases.
3. To receive and record reports of communicable diseases from local health officials and others
4. To investigate outbreaks of disease, where necessary, and supervise local health measures in times of epidemics.
5. To make necessary laboratory diagnoses and studies.
6. To manufacture and distribute serums, vaccines, and prophylactics
7. To enforce interstate and intrastate quarantine.
8. To distribute educational literature.
9. To cooperate with federal and local public health authorities.[31]

The duties of local health authorities have been listed as:

1 To enforce all state health laws and regulations and all local health ordinances and rules and regulations.
2. To adopt necessary local regulations for the control of communicable disease.
3. To receive and record reports of disease from physicians and others, and to report all such cases to the state health authorities in accordance with law.
4. To investigate all cases of disease, carriers, and contacts.

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[30] Kerr, J. W , and Moll, A A. *Communicable Diseases: An Analysis of the Laws and Regulations for the Control Thereof in Force in the United States.* U. S. Public Health Service, Public Health Bulletin No 62, July 1913. Washington, D. C.: Government Printing Office, 1914 699 p

[31] Tobey, James A. *Public Health Law* New York: Commonwealth Fund, 1939. p. 133-34.

5. To isolate or quarantine cases of communicable diseases, and assist quarantined persons
6. To furnish vaccines, serums, etc.
7. To perform disinfection where necessary.
8. To supply laboratory service.
9. To attend conferences with state health officials for concerted measures in the suppression of disease.[12]

The powers and duties listed have long been recognized as the basic areas of activity designed to safeguard the school and the community against the onslaught of contagious diseases.

In recent years the powers granted to boards of health have been extended to include, under certain conditions, the supervision of sanitation and health protection exercised by local boards of education. This has resulted in the general acceptance of nationwide regulations and laws designed to insure the health and general well-being of all the people in the suppression of disease.

The general health services, as provided under a board of education, may be summarized by the following statements:

1. Under statutory provisions the board of education may employ a school physician, dentists, oral hygienists, school nurses, psychiatrists, and visiting teachers

2. The responsibility for the implementation of health service in the schools is shared by (a) administrative officers, (b) teachers, (c) school nurses, and (d) the school physician. The general enforcement of rules and regulations under state laws is vested in the department of health.

3. Teachers and nurses are cautioned against giving medical advice to parents or children, recommending physicians, prescribing remedies, giving medical treatment other than first aid, and the criticism of doctors in conversation with parents and children This is merely the observation of the ethics of professional relationships generally accepted.

4. School nurses are expected to make personal visits to the homes of the children enrolled in the several schools. Absence may be checked over the telephone, but there are conditions which demand firsthand investigation and personal visits to consult with parents in the home.

5. In case there appear to be irregularities in the matter of quarantine, or the need of medical attention, direct contact is made with the department of health.

6. In case of serious accidents, the home should be notified at once. If the parents cannot be reached, the patient should be taken to the nearest hospital, where arrangements can be made for medical care The board of education is not liable for accidents sustained by pupils unless they are in the paid employment of the board of education.

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[12] Tobey, James A , *op cit*, p 134

7. Routine examinations are of major importance. Teachers are expected to be constantly on the alert to guard against children returning to school or remaining in school if there are indications of illness Such children should be excluded from the classroom until examined by the nurse or physician

8 Pressure should be brought to bear upon parents in order to prevent the practice of permitting pupils to attend school when they are ill or not in fit physical condition. Often children attend school at the time when they are in the most highly contagious stage of a disease. Parents alone are responsible for the spread of contagion under these conditions.

9. There are some parents who may file objections to having children pass thru the periodic examinations. When the state law sustains them in this position, the school authorities have the right to exclude these children from school if there are reasons to believe they are not in fit physical condition to be in school. Children may be excluded from school if, in the opinion of the school authorities, they are not in fit condition to be in school. This rule supersedes orders from the health department or statements from physicians

In order to insure the most efficient operation of a school health program, it must be considered as a cooperative program calling for the intelligent support of parents, teachers, social workers, physicians, and all social and health agencies of the state and local communities.

Legislative Problems in the Promotion of Health Education

Looking back upon the beginnings of school health legislation in the United States, we are impressed by the slow but steady gains in the recognition of the importance of health education both in the schools and in the general field of public health. During the past sixty years the legislatures in all the forty-eight states have adopted laws of more or less far-reaching significance in the promotion of health, sanitation, and physical efficiency.

School Law versus Public Health Law

One factor in the retardation of legislation for the promotion of health education is to be found in the confusion incident to the administration of the laws enacted for health education, sanitation, and hygiene. In some instances the laws designed to control and direct school health activities are imposed upon local boards of education as specific provisions in the statutes. In other instances the administration of the law is vested in state and local boards of health. As the school districts are often conterminous with the boundaries of the municipalities, the health laws of the state and community control the school situation. While there have been decisions in ruling case law that uphold the right of the schoolboard to exercise full control in the administration of the law, where conflicts between the school law and public health law occur, it is generally held that the public health laws shall prevail. This interpretation is justified upon the ground that the protection of the larger community interests is of paramount importance. It has been ruled that in an emergency situation, when epidemic conditions are developing, the public health authorities shall take charge of the situation.[33] This is the preferable procedure to be followed by school administrators, even in situations where the statutes may limit the authority of boards of health. Success in the development of a school health program is definitely dependent upon community cooperation, and there must be complete harmony in the interpretation and the administration of the laws. In carrying out professional duties, the public health officers have the right to enter and inspect the school buildings, pupils, teachers, and other employees of the schools at any time in order to discover conditions that may threaten the health of the community. It has been decided that a schoolboard may be held to the same accountability for the compliance with law in matters of health and sanitation as obtains in the case of individuals or corporations.

Mandatory versus Permissive Legislation for School Health Work

An examination of statutes pertaining to school health legislation will show that some laws are mandatory while others are permissive. It is important for school administrators to note this distinction, because of the modification of methods to be employed in the application of the law in given situations. While the majority of the states have made the teaching of physiology, hygiene, physical education, and the effects of alcohol and narcotics mandatory, in some of these states physical examinations of pupils and immunization are not mandatory. In some instances the school authorities must rely upon the police power of public health officials to enforce the law in the control of epidemic, or threatened epidemic, conditions. A cooperative program of administration between schoolboards and public health boards is again mentioned as being highly desirable in the interest of a unified public health program. As the population increases and people live in more highly congested areas, the trend in school health legislation has tended to become mandatory in the enforcement of rules and regulations for protection against disease, physical impairment, and the improvement of sanitary conditions.

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[33] Globe School District v. Globe Board of Health 20 Ariz. 208.

State Legislation on Health Guidance and Health Education

An examination of the study by Rogers reveals the present status of legislation governing the teaching of health and the provisions for health guidance in the schools of the several states.[34] While the report shows mandatory legislation for the teaching of health and for health examinations, there are wide variations in the nature of the courses presented in health education, and the health examinations show varying degrees of thoroness. In many schools there are no health examinations, altho the statutes provide for them. Since the importance of health examinations has long been accepted as a proper function of efficient school administration, it appears that school administrators who fail to provide adequate programs of health education and administration may be charged with neglect in the discharge of their professional duties in situations where the statutes make provisions for health examinations. Generally, legislation for school health provides for (a) health instruction as found in the teaching of physiology and hygiene, (b) the formation of correct health habits, and (c) corrective procedures which seek to discover and correct physical defects thru health examinations. It may be said that the discovery and correction of physical defects is the most important function of the health program of the school and has been so indicated in the legislation dealing with this phase of school health.

The Coordination of Effort in the Promotion of Health Legislation

No recent trend in the interests of school health legislation holds more promise for the advancement of the entire health program than that of the effort being made to coordinate and correlate the various social service agencies found in all communities thruout the nation that are engaged in the promotion of the health education movement. At the present time there is a wasteful duplication of money and effort in much of the education and the social service work in many communities. Under the leadership of local survey committees, many studies are being made to determine the number of different agencies engaged in social service and educational work in local communities. The studies made by the survey committees include the historical background of the organization, the aims and objectives, the services rendered, and cost of operation. While surveys of this type have been completed in many communities, the report of the Welfare Federation of Cleveland, Ohio,[35] is a commendable example of the type of study that may be made of social service in a large metropolitan area. An illustration of a social service survey in a smaller suburban community is found in the community welfare report prepared and published by the Community Welfare Council of Oak Park and River Forest, Illinois.[36]

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[34] Rogers, James F., *op. cit.*, p. 13-15. Revised edition, p. 10-15.

As an example of the coordination of the work of agencies for the promotion of legislation and health service upon a nationwide basis, attention is called to the National Conference for Cooperation in School Health Education, discussed in Chapter XV. Steps toward the coordination of the work of agencies interested in health education are prevented, in many sections of the United States, because of jurisdictional conflicts due to administrative controls. Enabling legislation for making possible the coordination of agencies contributing to school health education is of paramount importance. The consideration of this objective should be included in every administrative program looking toward the promotion of health in education. School administrators interested in formulating a basic program in health education will find constructive suggestions in the 1941 report of the Joint Committee on Health Problems in Education.[37]

Extra-Legal Promotion of Health Education

While the program of health education has been largely determined thru specific legislation to be found in the school law, the progress in the trends toward the extension of health service and health education has been determined to a considerable degree by extra-legal agencies. In this category we may place those organizations affiliated with the National Conference for Cooperation in School Health Education; state education associations; the Educational Policies Commission;[38] the White House Conference on Child Health and Protection;[39] scientific organizations engaged in research in the fields of health and sanitation; the American Association for Health, Physical Education, and Recreation; and the American School Health Association. Other influential organizations are listed in the Appendix of this book. School administrators interested in a self-survey for the purpose of evaluating health education in their own school systems will find the *School Health Appraisal Form,*[40] published by the Department of Biology and Public Health of the Massachusetts Institute of Technology, of marked assistance. The organization and administration of a school health program is developed in the volume by Wood and Rowell[41] which has been in general use over a period of years.

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[35] Bing, Lucia *Social Work in Greater Cleveland* Cleveland, Ohio: Welfare Federation of Cleveland, 1938. 248 p

[36] Borwell, Carrie Lee. *How Public and Private Agencies Are Serving Oak Park and River Forest* Oak Park, Ill Community Welfare Council, 1940. 57 p.

[37] National Education Association and American Medical Association, Joint Committee on Health Problems in Education. *Health Education.* Washington, D. C.: the National Education Association, 1941. 368 p.

Legislative and Administrative Trends

It will be noted that from the earliest inception the program of health education has been a community enterprise. All the children of all the people, as well as all the people, have been concerned. The early enabling legislation recognized that the benefits derived should accrue to the majority of the people even at the risk of curtailing the rights of the minority. This principle is still fundamental in school health legislation.

Health Legislation and Social Reform

The consideration of trends in school health legislation would not be complete without mention of certain humanitarian projects designed for health protection and implemented thru state and federal agencies.[42] These are promoted thru the United States Public Health

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[38] National Education Association and American Association of School Administrators, Educational Policies Commission *The Purposes of Education in American Democracy.* Washington, D. C: the Commission, 1938 157 p.

[39] White House Conference on Child Health and Protection *White House Conference, 1930.* New York: Century Co., 1931 365 p

[40] Massachusetts Institute of Technology. *School Health Appraisal Form* Cambridge, Mass the Institute, 1930 73 p

[41] Wood, Thomas D, and Rowell, Hugh G. *Health Supervision and Medical Inspection of Schools.* Philadelphia W. B. Saunders Co, 1927 637 p.

[42] Tobey, James A. *The National Government and Public Health* Baltimore: Johns Hopkins Press, 1926 423 p.

Service, the Children's Bureau of the Department of Labor, the Division of Vital Statistics, the Food and Drug Administration of the Department of Agriculture, the Bureau of Animal Industry, the Bureau of Narcotics, the Federal Trade Commission, the Bureau of Dairy Industry, the Office of Indian Affairs, the Bureau of Home Economics, the Bureau of Labor Statistics, the Women's Bureau of the Department of Labor, the National Youth Administration, the Office of Education, the Post Office Department, the Bureau of Mines, and the Social Security Act, which is designed to provide grants-in-aid to the states for old-age assistance and to meet social problems arising from unemployment.

Legislative Trends Relative to Tort Liability

As life in the present social order has become increasingly complex owing to the inventions of the machine age, the increase in the density of population, and the expansion of activities included in the curriculum of the schools, more attention must be given to safety education and accident prevention. The increase of accidents on schoolgrounds, in shops, and in laboratories, together with the corresponding increase of lawsuits in support of claims for damages, have resulted in legislation dealing with the tort liability of boards of education. The general doctrine of tort responsibility of boards of education and school officers during the past years has been to exempt school corporations for liability in noncontract injuries inflicted by them upon the person or property of the teacher, pupil, or any other person. Most court decisions have been based upon the theory that the board of education is not liable for the consequences of the breach of public duty or the neglect or wrong of its officers, unless there is a statute imposing such liability.

Court decisions pertaining to the tort liability of boards of education have been handed down in nearly every state in the Union. There is a wide divergence in these opinions, which may be explained by the fact that in certain states court rulings have been based upon the doctrine of common law which holds that the state and agents of the state are recognized as sovereign power and as such "can do no wrong." This viewpoint exempts the government from tort liability. Recent legislation in several states has resulted in statutory provisions which hold boards of education liable, under stated conditions, for injuries sustained on school premises. As the result of this legislation, boards of education in certain states have been required to pay out considerable sums of money for damages assessed by the courts. This trend in legislation has caused boards of education in some states to seek protection by securing insurance coverage against tort liability. It has been pointed out that the apparent danger in this administrative trend toward allowing claims for damages sustained by persons upon school premises is to be found in the possibility that legislation of this type may result in the serious impairment of the educational functions for which the schools of the nation were established.[43] The important principles involved in the proposed legislation relative to the tort liability of boards of education are (a) the principle of proximate cause and (b) the principle of contributory negligence.

Legislation for the Control of Radio Broadcasting

Since the radio is in common use for disseminating information relative to medical and health education and for promoting the sale of proprietary medicines, radio control has become a matter of significance. Court decisions have been handed down in a number of cases instituted under the Federal Communications Commission, in which operating licenses have been denied to individuals who used the radio to broadcast an alleged cancer cure, to attack scientific medicine, to oppose vaccination,[44] and to attempt the diagnosis of diseases and the prescription of drugs and remedies over the radio.[45] Health education in our elementary and secondary schools should include courses designed to develop an awareness as to the importance of a discriminating attitude in evaluating statements made over the radio relative to health guidance.

The Relation of Teacher Tenure to Health Legislation

The adoption of legislation authorizing the issuance of continuing contracts to qualified persons in teaching service has become a statutory provision in many states. Because of tenure laws a number of court decisions have been handed down in cases involving boards of education when attempts have been made to enforce regulations adopted by these boards relative to ways and means of determining health and physical fitness of teachers. In a case involving the board of education of the city of Amsterdam, New York, a teacher on tenure was dismissed because of physical disability. An appeal from the ruling of the board resulted in a court decision which held that the board of education had the right to dismiss a teacher for physical disability upon the recommendation of the medical inspector.[46] Another case presented a situation in which a tenure teacher refused to comply with a ruling of the board of education that required a health examination by a physician selected by the board. While the teacher indicated a willingness to submit to an examination by her personal physician or the medical board of the teachers retirement system, the board of education refused to accept an alternative arrangement. The state commissioner of education ruled in favor of the teacher, holding that there were no specific statutory powers, inherent or implied, vested in the board of education of the City of New York, making physical examinations of teachers under permanent contracts mandatory. The court upheld the opinion rendered in the ruling of the state commissioner of education.[47] The two citations here given are illustrative of similar court decisions that may be rendered from time to time relative to attempts of school administrators to introduce rules and regulations for the establishment of a program of supervision in health education. Only carefully planned and intelligent legislation will prevent contradictory court decisions based upon contractual relations between teachers and boards of education.

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[43] Rosenfield, Harry N. *Liability for School Accidents.* New York Harper and Brothers, 1940 220 p

[44] U S. v Baker (1936), 18 F. Supp 48.

[45] Brinkley v Hassig (1936), 83 F (2d) p 351

Curriculum Changes in School Health Education

Legislation governing school health education is undergoing constant modification thru the amendment of old laws and the enactment of new legislation to meet the needs of a changing social order. The increasing demands for more complete health guidance of pupils and teachers, the provisions offered for dental and medical care thru the instrumentality of the school, the program of cooperative medicine, and statutory provisions for the construction and sanitation of school buildings are still moot questions in the consideration of legislation for health service in the schools.

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[46] Louchs vs Board of Education, City of Amsterdam 16 N. Y S (2d) 733

[47] Board of Education, City of New York vs. Graves 24 N. Y. S. (2d) 644.

If the schools are to meet the demands incident to trends in legislation for a more adequate school health program, changes in the curriculum are necessary. The consensus of organizations closely identified with the research in fields related to health education points to the need of a restatement of the underlying philosophy, together with the aims and objectives, of health education in the modern school. There is a need for a recognition of the fact that "the whole child" attends school, and that only a small fraction of his time is spent in school. As the curriculum is made up of the sum total of the child's experiences in school and out, curriculum builders interested in the field of health education will need to be concerned with the total environment of the school child.

Parents must be interested in the program of health education if health habits are to be formed in the habit-forming years of the lower elementary school. Better materials of instruction must be provided for the courses in physiology and hygiene now offered, and a definite correlation established between the courses in science, the social studies, and life in home, school, and community. There is a need for more adequate preparation and certification of teachers for instructional services in the presentation of the health courses of the revised curriculum. A final trend in curriculum reorganization is found in the suggestion that the major educational outcomes will be in the development of habits, skills, knowledge, attitudes, and ideals, which shall result in a personal program for healthful living thruout the life of the individual. These end products may be emphasized thru a program of educational guidance and the evaluation of individual school progress at regular intervals of time by the school authorities.

The Health Factor in the Selection and Training of Teachers

The trend toward the demand for periodic health examinations for teachers has become increasingly important as an administrative procedure during recent years. Provisions for health education are recognized as an integral part of a well-planned administrative program for the in-service training of teachers. It is a generally accepted fact that the most important responsibility of the school administrator is the selection of the teaching force. The major difficulty in this administrative function is to be found in the inability to foretell the type of service a teacher will render in a given situation.

It is unreasonable to place all the responsibility for the professional success of a teacher upon the teacher-education institutions because of the wide range of variables that enter into the situation. There are, however, certain steps that may be taken thru rules and regulations governing the admission of students into teacher-training work. Standards for health and physical fitness may be adopted and placed upon an objective basis and should be given consideration in the admission to colleges of education as well as in the certification of teachers. In a discussion of health education for preservice teachers, in the report of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, the following statement is worthy of note:

> Every pupil has a right to have, as his counselor and instructor, a cheerful, well-integrated, and well-informed teacher; a leader whom he wants to emulate and follow The parents of pupils have a right to expect that the teacher to whom they have entrusted their children has, in good measure, vitality, abundant health, and those standards and ideals which they want for their children The school which employs the teacher has a right to expect that she will be able to give full-time, efficient service. Furthermore, every teacher wants to be a desirable influence upon those in her care; she wants to be fit for her professional work; she wants to be successful and happy in the approval of her fellow teachers, pupils, and community. The teachers college has a responsibility to respect these rights and desires.[48]

Legislation looking toward higher standards for the certification of teachers should include carefully evaluated requirements to insure both mental and physical fitness as among the first requirements for admission to teacher-training institutions. Periodic examinations to determine health and physical fitness of teachers while in service should be included in every program of educational administration.

In framing legislation designed to modify curriculum procedures in health education, the tendency toward nationwide standardization should be avoided. Geographic controls, national and ethnic backgrounds of the people, and social conditions vary greatly in different parts of the United States. These demand freedom of choice in the organization and administration of the school health education program.

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[48] National Education Association and American Medical Association, Joint Committee on Health Problems in Education, *op. cit.*, p 296.

If legislation for the promotion of the school health program is to be enacted upon a nationwide basis, those responsible for leadership in the movement must possess a knowledge of existing legislation as well as proposed legislation. This can best be acquired thru the careful study of the codes, bulletins, and reports issued by the state and federal authorities. This task is definitely a responsibility to be assumed by administrative officers who are interested in shaping sane legislation for the establishment of a program of school and community health and by so doing provide instruction and leadership in laying the foundation for the health and physical well-being of the citizens of tomorrow.

QUESTIONS REGARDING SCHOOL HEALTH PROBLEMS

In the field of health education there are few arbitrary standards that can be prescribed for all school systems. Conditions vary widely, and with proper leadership effective health education programs can be developed even under adverse conditions. As in many other areas of education, excellent results are obtained: (a) when an administrator has a vision of future possibilities, (b) when the necessary personnel and equipment are assembled, (c) when cooperatively the administrator and his fellow workers develop mutual enthusiasms and objectives, and (d) when the plans are put into operation and periodically reviewed and revised.

The following list of questions should be helpful with respect to the four steps just outlined. Issues such as these need to be discussed freely in administrative councils, teachers' meetings, and study groups.

CHAPTER I. A POINT OF VIEW ON HEALTH EDUCATION

1. What are the fundamental purposes of education in American democracy?
2. Why is health education a primary phase of a modern educational program?
3. What are the basic principles of health education in the United States?
4. Is the youth of today more healthy than formerly?

CHAPTER II ORGANIZATION AND ADMINISTRATION OF THE GENERAL PROGRAM

1. What are the modern educational meanings given to the terms "health" and "health education"?
2. Why is a modern program of health education incomplete when it is limited merely to factual information about health?
3. What are the major areas of a health education program and how is each provided for in the school system?
4. What is the superintendent's role with respect to the school system's health program?
5. What machinery is provided to guarantee that all personnel and agencies of the school system assigned health education functions will work toward mutually accepted goals?
6. Has the school system assumed its proper leadership opportunities with respect to the health needs and services of the community?

CHAPTER III. GUIDANCE OF INDIVIDUAL PUPIL HEALTH

1. Does the school have a complete physical record of each child before school entrance?
2. Are continuous records kept of the physical history, condition, and treatment of each child?

3. Are special examinations given to cases referred to teachers and nurses because of underweight, nervous condition, sickly appearance, frequent illness, loss of weight or failure to gain, poor posture, fatigue, and backwardness in schoolwork?
4. Is a report of the examination and the physician's recommendations made available to all teachers and departments coming in contact with the child when the interests of the child demand it?
5. Does the teacher, trained in detecting early signs of departure from normal physical health, make a rapid morning inspection of all children for the purpose of determining whether their health condition justifies their presence in school?
6. Are the children with defects brought at once to the attention of the school physician or nurse (or parents if there is no nurse or physician)?
7. Is there someone on the faculty whose business it is to see that children who are beyond the comprehension and help of teachers, or who are for other reasons out of harmony with their school life, are studied with the aim of adjusting these difficulties?
8. Is there a plan for study of pupils with poor posture and are plans made for helping these pupils?
9. Is provision made for reference to the proper health authorities of all boys and girls who need medical attention?
10. Is notice of defects discovered in physical and dental examinations sent to parents and followed wherever necessary by nurses' home visits until corrections are secured?
11. Are parents encouraged to visit the school for doctor, nurse, or teacher interviews regarding the health of the child?

CHAPTER IV. SCHOOL HEALTH INSTRUCTION PROGRAM

1. Have teachers, principals, supervisors, and superintendent participated in a program of curriculum construction in health education?
2. Do all teachers have a clear understanding of the objectives of health education?
3. Are health instruction opportunities definitely provided and recognized in each school?
4. Is health instruction directly based on the needs, interests, and abilities of children?
5. Do teachers specifically study their groups in order to discover such needs, interests, and abilities?
6. Is the instructional emphasis placed on positive health factors?
7. Are children taught as individuals whose health needs differ?
8. Have competition in and awarding of prizes for health performance or health attainment been abandoned?
9. Have suitable provisions been made for classroom space? Credit? Instructional materials?
10. Are scientific, valid, teaching materials provided for all grades and classes?

11. Is health instruction in the primary grades centered around daily living experience?
12. Do the intermediate grades provide opportunities for increased understanding of health problems while still centering emphasis on daily experience?
13. Is health education a required area of instruction in the junior high school? The senior high school?
14. Have suitable provisions been made for programs of sex education? Temperance education? Safety education? Adult education?

CHAPTER V. HEALTH INSTRUCTION IN RELATED AREAS

1. Is the staff aware of the opportunities for relating many areas of instruction to the health needs and interests of pupils?
2. Who is responsible for coordinating the health education activities in science, home economics, social studies, and other related areas of instruction?
3. Is there an interdepartmental committee in each secondary school to coordinate health instruction programs conducted by various departments?
4. Does the administration encourage the teaching of health thru related areas of study and provide the means whereby such instruction is made possible and effective?
5. Are teachers of the various instructional areas organized into committees and conferences designed to develop activities and methods to promote the health education program?
6. Are all areas of instruction utilized to develop the interests and needs of pupils in the field of health?
7. Is provision made for regular reviews and discussions of the effectiveness of health instruction thru science, home economics, physical education, and other instructional areas?

CHAPTER VI. HEALTH ASPECTS OF PHYSICAL EDUCATION AND RECREATION

1. Have teachers, supervisors, and administrators cooperatively constructed a course of study in physical education for elementary pupils? Secondary pupils?
2. Is adequate instruction and supervision in physical activities furnished by teachers fully informed concerning the interests and physical capacity of pupils?
3. Is ample provision made in the way of space and apparatus for suitable physical activities for children of all ages?
4. Is the formation of good health habits encouraged in connection with development of physical strength and ability?
5. Does the physical education program try to contribute definitely to the development of personality and character thru the formation of desirable habits?
6. Is all apparatus safe and in such condition that accidents cannot occur from faults in the apparatus itself?

7. Has the school medical adviser or director of health education discussed with teachers the precautions needed to prevent pupils from participating in activities which are too strenuous or inappropriate to their age?
8. Have satisfactory procedures been developed for modifying physical education for handicapped pupils?
9. Does the daily program give opportunity for recreation and social activities in addition to the regular physical education periods (extracurriculum activities, student organizations, clubs, assemblies, and so forth)?
10. Are community recreation facilities and leadership available to supplement that of the school?
11. Are school facilities used for community recreation in out-of-school hours? During vacation periods?

CHAPTER VII MENTAL HYGIENE IN THE SCHOOL PROGRAM

1. Does the health education program provide for mental health as well as physical health?
2. Are complete and continuous health records, including personality records, kept for each child thruout his school life?
3. Is the classroom teacher helped to recognize personality problems in their early stages and encouraged to refer these problems to the mental hygiene staff?
4. Does the school provide for the study of personality difficulties thru an adequately trained mental hygiene staff?
5 Do teachers have the help of "visiting teachers" or specially trained guidance teachers in their efforts to help pupils with problems?
6. Have the principal and his staff recently studied teaching procedures and their effect on the emotional development of pupils?
7 Are administrative and supervisory procedures of the type which help teachers to feel adequate, happy, and secure?
8. Is there an absence of tension in the classroom?
9. Do disciplinary actions of teachers help pupils or merely punish them?
10. Does the school provide a desirable outlet for feelings in music, art, play, and social activities?

CHAPTER VIII. SCHOOL PROGRAMS FOR PHYSICALLY EXCEPTIONAL CHILDREN

1. Has a survey been made of the extent of special disabilities among those attending the local schools?
2. Has consideration been given to the need for special classes and other adjustments of the school program to meet the needs of the physically exceptional child?
3. Is transportation to and from school provided for the physically exceptional pupils?
4. Has provision been made for the physically exceptional child with respect to lavatory facilities, lunchrooms, and play equipment?

5. Does the school system provide an instructional program which includes the necessary therapeutic activities for improvement of physically exceptional cases?
6. Are the exceptional children being taught by teachers with special preparation?

CHAPTER IX. COMMUNICABLE DISEASE: GENERAL CONTROL MEASURES

1. Do all the pupils and does the entire school personnel know the symptoms of the common communicable diseases, and are there organized procedures to prevent the spread of epidemics?
2. Are printed, mimeographed, or typed instructions available to teachers regarding exclusion and readmission of cases of illness?
3. Is the teacher trained to observe, and does she watch during the day for appearance of signs indicating development of contagious condition?
4. Is the teacher trained to isolate pupils immediately at the first symptom of abnormal conditions?
5. Are all pupils showing signs of possible communicable disease promptly isolated and sent home under safe escort?
6. When a child is excluded, is a note sent home advising the parent that the child should not be returned to school until he can do so without danger to himself or others?
7. Is the health department notified when exclusion is made for acute communicable disease?
8. Is a physician's certificate, satisfactory to the school authorities, essential for readmission after a child has been absent because of illness?
9. Is the child taught to safeguard others by avoiding close contacts when he is ill and by using his handkerchief when sneezing or coughing?
10. Are older children encouraged to assume responsibility of self-inspection and to show good citizenship by remaining at home when not fit for school?

CHAPTER X COMMUNICABLE DISEASE: TYPES AND SPECIFIC CONTROLS

1. Is the child examined by school physician or certified by health department in case of acute communicable disease? By family doctor?
2. Is every effort made to have all children protected against diphtheria?
3. Is every effort made to have all children protected by vaccination against smallpox? Are written certificates of successful vaccination required of all pupils entering school?
4. During the daily inspection does the teacher look especially for pallor or rash, swollen glands, or eruptions; nits and so forth; redness of the eyes, lids, or eyeball; discharging ears; running nose; and inflammation of the mouth or throat?
5. Are children who have been excluded from school because of diphtheria, scarlet fever, measles, whooping cough, smallpox, mumps, poliomyelitis, and meningococcus meningitis readmitted according to policy agreed upon by the board of education and the department of health?
6. Are all children inspected during epidemics?

CHAPTER XI. INJURIES AND EMERGENCY ILLNESS

1. Is there a first-aid outfit containing properly selected materials always available in each building?
2. Is a first-aid manual of instructions available in each cabinet?
3. Are a few cots available in separate rooms for boys and girls?
4. Is there a clearly understood plan of procedure and responsibilities in cases where first aid is needed?
5. Are all teachers instructed in first-aid treatment?
6. Are the children taught what to do and what not to do when playmates are injured?
7. Is there a plan whereby first-aid cases are placed as promptly as necessary under the care of competent medical personnel?
8. Is nursing inspection for the detection of minor infections and infestations carried on in all elementary schools?

CHAPTER XII. HEALTHFUL SCHOOL ENVIRONMENT

1. What systematic efforts are made by school officials to obtain satisfactory school sites and to construct and maintain attractive school plants?
2. What efforts have been made to study and prevent the disturbing noises in and about school buildings?
3. Has any attempt been made to provide school buildings with adequate lighting under all types of weather conditions?
4. Are the buildings equipped adequately for heating and ventilating demands, and has the school personnel been trained to make efficient use of all equipment?
5. Are the school custodians trained to keep buildings and equipment in clean, sanitary, and safe condition?
6. Are the teachers and principals encouraged to increase the beauty and attractiveness of their schools?
7. Are the pupils taught to develop the attractiveness of their schools and to carry over ideas of landscaping and art into their homes?
8. What studies have been made of the artistic and efficiency values of various paints used in maintaining school buildings?
9. Has an attempt been made to eliminate from instructional methods and programs the unnecessary pressures which result in debilitating fatigue?
10. Are the parents invited to cooperate with the school in providing an environment free from unnecessary worries, fears, and tensions?

CHAPTER XIII. FUNCTIONS AND PREPARATION OF SCHOOL HEALTH PERSONNEL

1. In the elementary school, is the chief responsibility for the health education of the child vested in the classroom teacher?
2. In high schools, is there a health counselor or other agent who is responsible for the health supervision of all students?

3. Does the supervisor of health education possess those characteristics of physical health and personality that favor adaptation to school and community situations?
4. Does the supervisor of health education have thoro grounding in the subject-matter of health education and the allied fields of biological sciences, nutrition, psychology, and sociology?
5. Does the supervisor of health education have thoro training in the principles and technics of general supervision with reference to both elementary and high-school levels?
6. Are all special health workers as fully prepared as are those in other lines of work?
7. Are all teachers prepared with a wide range of scientific subjectmatter basic to health education?
8. Is opportunity furnished for in-service training of teachers in health education?
9. Is the administration of all health work of any school directly under the principal of that school?

CHAPTER XIV. ADMINISTRATIVE PRACTICES AFFECTING THE HEALTH OF THE SCHOOL PERSONNEL

1. Is each teacher urged to set a good example of health for her own sake as well as for that of her pupils?
2. Does the school require health qualifications for the employment of teachers?
3. Are new teachers placed on probation as regards physical conditions (defects or diseases) which can be improved or removed?
4. Does the school analyze teacher absences for the purpose of determining methods of safeguarding the teacher's health?
5. Does the school provide leaves of absence with some remuneration for recuperation and rest whenever the condition of the teacher warrants it?
6. Is a health examination required of all teaching personnel each year?
7. Is immunization of teachers and other school personnel required?
8. Is the number of pupils assigned to any class beyond reasonable limits?
9. Are extracurriculum activities included in teacher load?
10. Does every school building include fully equipped teachers' rest rooms?
11. Are school recreational facilities available for teachers?
12. Is provision made for hot lunch for teachers in all buildings?
13. Is provision made for a satisfactory place in which the teacher may work after school?
14. Does the school provide wholesome living conditions for teachers in communities where satisfactory accommodations are not available?
15. Is a suitable pension or retirement system provided?

CHAPTER XV. COORDINATION OF HEALTH AGENCIES

1. Is there a clear-cut understanding of the administrative relationship between the activities of the local health department and the health activities of the school system?

2. Have school officials made a survey of the types and activities of community agencies interested in health programs?
3. Is there any provision for the articulation of the activities of local health agencies in order to improve the health education of the school child?
4. Does the school personnel cooperate with social service agencies in discovering and helping in cases involving pupils?
5. What attempt has been made by school personnel to utilize the resources of state agencies in the field of health?
6. To what extent has the local school program in health education utilized the services and publications of national health agencies?

CHAPTER XVI. LEGISLATIVE AND LEGAL ASPECTS OF THE SCHOOL HEALTH PROGRAM

1. What are the major, general state laws, state schoolboard rulings, and local ordinances that affect the health of the school child?
2. What authority do these laws grant to boards of education, administrators, and teachers with respect to health education?
3. Are the building codes applicable to the local community adequate to protect the health and safety of pupils and teachers?
4. To what extent are school and health officials supported by legislation with respect to immunization, inspections, and other preventive health measures?
5. In what respects under the laws of the state do the powers and duties of school officials and public health authorities conflict and overlap?
6. To what extent should legislation for health education and disease control be mandatory and to what extent should it be permissive?
7. What constructive trends may be noted in legislation with respect to the coordination and improvement of public health agencies?
8. To what extent are teachers and boards of education legally liable in case of accidents to pupils?
9. What legislation is needed to reconcile the demand of teachers for permanent tenure with the demand of the public that provisions be made for the examination and removal of teachers suffering from serious illnesses?
10. What is the responsibility of superintendents of schools in shaping legislation for the improvement of programs of school and community health?

REFERENCES ON HEALTH EDUCATION

The following list of books, bulletins, and pamphlets has been selected from among those that should be of interest to school administrators. For a longer list consult *Health Education* (see page 356) and the *Cumulative Book Index* (H. W. Wilson Company) available in many public libraries. Current articles appear in such publications as *Hygeia, The Health Magazine* (published by the American Medical Association), *Journal of Health and Physical Education* (published by the American Association for Health, Physical Education, and Recreation, Washington, D. C.), and *American Journal of Public Health* (published by the American Public Health Association, New York, New York). Many articles can be located thru the *Education Index* and similar guides. Other materials are mentioned in the list of "Organizations with Materials and Services of Use in Health Education" and the section on appraisal to be found in the Appendix.

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FRANK, LAWRENCE K. "The Education of Women in Terms of Their Needs and Opportunities Today." *Record of the 1939 Conference of the National Association of Directors of Physical Education for College Women. Part II: Lecture Sessions* Northfield, Minn.: the Association (Sec : Mabel J. Shirley, St. Olaf College), 1939. 40 p

JACK, HAROLD K. *Physical Education for Small Elementary Schools.* New York. A S Barnes and Co., 1941. 184 p. $1 60.

LAPORTE, WM. RALPH. *The Physical Education Curriculum.* Los Angeles. University of Southern California Press, 1940. 86 p.

MILLER, CHARLES E. *Physical Training.* St. Louis, Mo.: Fred Medart Manufacturing Co., 1941. 72 p.

NATIONAL EDUCATION ASSOCIATION and AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS, EDUCATIONAL POLICIES COMMISSION. *Educational Policies for Community Recreation.* Washington, D. C.: the Commission, 1940. 31 p. Free

U. S. DEPARTMENT OF LABOR, CHILDREN'S BUREAU. *Good Posture in the Little Child* Publication No. 219. Washington, D. C.: Government Printing Office, 1935. 25 p. 5¢.

WILLIAMS, JESSE F. *Principles of Physical Education.* Philadelphia: W. B. Saunders Co , 1938. 453 p $3.

CHAPTER VII. MENTAL HYGIENE IN THE SCHOOL PROGRAM

Ackerly, Spafford. "Rebellion and Its Relation to Delinquency and Neurosis in Sixty Adolescents." *American Journal of Orthopsychiatry* 3: 147-60; April 1933. Available in reprint form.

Baruch, Dorothy W. "Therapeutic Procedures as Part of the Educative Process." *Journal of Consulting Psychology* 4: 165-72; September-October 1940. Available in reprint form.

Beverly, Bert I. *In Defense of Children.* New York: John Day Co., 1941. 233 p. $2.

Kelley, Ida B., and Perkins, Keith J. *Further Studies in Attitudes, Series IV: An Investigation of Teachers' Knowledge of and Attitudes Toward Child and Adolescent Behavior in Everyday School Situations.* Studies in Higher Education No. 42. Lafayette, Ind.: Purdue University, 1941. 101 p. $1.

Martin, Alexander R. "Psychiatry in a Boys' Club." *American Journal of Orthopsychiatry* 9: 123-35, January 1939. Available in reprint form.

National Education Association and American Medical Association, Joint Committee on Health Problems in Education. *Mental Hygiene in the Classroom.* Washington, D. C., the National Education Association, 1939. 70 p. 15¢.

National Education Association, Department of Elementary School Principals. *Personality Adjustment of the Elementary-School Child.* Fifteenth Yearbook. Washington, D. C.: the Department, 1936. 448 p. $2.

National Education Association, Department of Supervisors and Directors of Instruction. *Mental Health in the Classroom.* Thirteenth Yearbook. Washington, D. C.: the Department, 1940. 304 p. $2.

Witty, Paul A., and Skinner, Charles E., editors. *Mental Hygiene in Modern Education.* New York: Farrar and Rinehart, 1939. 539 p. $2.75.

CHAPTER VIII. SCHOOL PROGRAMS FOR PHYSICALLY EXCEPTIONAL CHILDREN

Bentley, John E. *Problem Children.* New York: W. W. Norton and Co., 1936. 437 p. $3.50.

Betts, Emmett A., and Austin, Agnes S. *Visual Problems of School Children.* Chicago: Professional Press, 1941. 80 p.

Frampton, Merle E., and Rowell, Hugh G., editors. *Education of the Handicapped.* Yonkers-on-Hudson, N. Y.: World Book Co., 1938-40. Vol. I, "History," $2.40, Vol. II, "Problems," $2.80.

Heck, Arch O. *The Education of Exceptional Children.* New York: McGraw-Hill Book Co., 1940. 536 p. $3.75.

Martens, Elise H. *State Supervisory Programs for the Education of Exceptional Children.* Federal Security Agency, U. S. Office of Education, Bulletin 1940, No. 6. Washington, D. C.: Government Printing Office, 1941. 92 p. 25¢.

National Education Association and American Medical Association, Joint Committee on Health Problems in Education. *Open Air Classrooms.* Washington, D. C.: the National Education Association, 1937. 13 p. 10¢.

NEW YORK CITY PUBLIC SCHOOLS, COMMITTEE FOR THE STUDY OF THE CARE AND EDUCATION OF PHYSICALLY HANDICAPPED CHILDREN *Physically Handicapped Children in New York City.* New York: Board of Education, 1941. 91 p

CHAPTER IX. COMMUNICABLE DISEASE: GENERAL CONTROL MEASURES

FEDERAL SECURITY AGENCY, U. S PUBLIC HEALTH SERVICE. *The Control of Communicable Diseases.* Reprint No 1697 from the *Public Health Reports* Washington, D. C.· Government Printing Office, 1940. 61 p 5¢.

WISCONSIN STATE BOARD OF HEALTH. *Vital Information Concerning the Prevention and Control of Communicable Diseases.* Madison, Wis.· the Board, 1940 Chart.

CHAPTER X. COMMUNICABLE DISEASE TYPES AND SPECIFIC CONTROLS

NATIONAL FOUNDATION FOR INFANTILE PARALYSIS. *Doctor . . What Can I Do?* New York· the Foundation, 1941. 15 p.

NATIONAL FOUNDATION FOR INFANTILE PARALYSIS *Respirators· Locations and Owners* New York. the Foundation, 1941. 21 p.

O'CONNOR, BASIL *The Conquest of Infantile Paralysis.* New York· National Foundation for Infantile Paralysis, 1940. 15 p

PERRY, ETHEL B *Measles.* Chicago: American Medical Association, 1937 8 p. 10¢.

PERRY, ETHEL B. *Scarlet Fever.* Chicago: American Medical Association, 1937 10 p. 10¢.

STIMSON, A M. *The Communicable Diseases.* Federal Security Agency, U S. Public Health Service, Miscellaneous Publication No. 30. Washington, D. C · Government Printing Office, 1939. 111 p. 25¢.

CHAPTER XI. INJURIES AND EMERGENCY ILLNESS

AMERICAN NATIONAL RED CROSS. *First Aid Text-Book.* Philadelphia: P. Blakiston's Son and Co , 1937. 256 p. 60¢.

AMERICAN NATIONAL RED CROSS. *Life Saving and Water Safety* Philadelphia. P. Blakiston's Son and Co., 1937. 267 p. 60¢.

COBB, WALTER F. *Everyday First Aid.* New York· D. Appleton-Century Co , 1937 269 p. $1.50.

COLE, NORMAN B., and ERNST, CLAYTON H. *First Aid for Boys.* New York: D. Appleton and Co , 1931. 196 p. $1.50.

ELIASON, ELDRIDGE L. *Practical Bandaging.* Philadelphia: J. B. Lippincott Co., 1930 128 p $1 75.

U S. DEPARTMENT OF COMMERCE, BUREAU OF STANDARDS. *Safety for the Household.* Circular No. 397. Washington, D. C.: Government Printing Office, 1932. 102 p 25¢.

CHAPTER XII HEALTHFUL SCHOOL ENVIRONMENT

AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS. *Safety Education.* Eighteenth Yearbook. Washington, D. C.: the Association, a department of the National Education Association, 1940. 544 p. $2.

BETZNER, JEAN, compiler. *School Housing Needs of Young Children.* Washington, D. C.: Association for Childhood Education, 1939. 40 p. 35¢.

CARPENTER, ROWENA S.; HANN, HELEN N.; and YEATMAN, FANNY W. *Menus and Recipes for Lunches at School.* U. S. Dept. of Agriculture, Bureau of Home Economics, Miscellaneous Publication No. 246. Washington, D. C.: Government Printing Office, 1936. 25 p. 10¢.

ENGELHARDT, N. L., and ENGELHARDT, N. L., JR. *Planning the Community School* New York: American Book Co., 1940. 188 p. $2.50.

FEDERAL WORKS AGENCY, U. S. HOUSING AUTHORITY. *Better Housing, Better Health.* Washington, D. C.: Government Printing Office. 12 p. Free

FEDERAL WORKS AGENCY, U. S HOUSING AUTHORITY *Housing and Welfare.* Report of survey conducted by U. S. Housing Authority and Social Security Board. Washington, D. C.: Government Printing Office, 1940. 53 p. Free.

HATHAWAY, WINIFRED. "Lighting the Rural School." *Public Health Nursing* 27. 453-56; September 1935. Available in reprint form.

JACKSON, EDWARD. *Guarding the Sight of School Children.* Publication 218. New York: National Society for the Prevention of Blindness, 1936. 12 p 10¢.

METROPOLITAN LIFE INSURANCE COMPANY. *The Custodian and the School Child.* New York: the Company. 16 p. Free.

NATIONAL EDUCATION ASSOCIATION and AMERICAN MEDICAL ASSOCIATION, JOINT COMMITTEE ON HEALTH PROBLEMS IN EDUCATION. *Conserving the Sight of School Children.* New York: National Society for the Prevention of Blindness, 1935. 54 p. 35¢.

NATIONAL SOCIETY FOR THE PREVENTION OF BLINDNESS. *Safeguarding the Eyes of Children* Publication 216. New York: the Society, 1936. 8 p. 5¢.

NATIONAL TUBERCULOSIS ASSOCIATION. *Healthful School Living.* New York: the Association, 1938. 15 p.

PHELAN, ANETTE M, and LANGDON, GRACE. *Eye Health of Young Children.* Publication 176 New York: National Society for the Prevention of Blindness, 1935. 15 p. 10¢.

ROGERS, JAMES F. *Safety and Health of the School Child.* U. S. Dept. of the Interior, Office of Education, Pamphlet No. 75 Washington, D. C.: Government Printing Office, 1937. 29 p. 10¢.

VILES, NELSON E *The Custodian At Work.* Lincoln, Nebr.: University Publishing Co, 1941. 391 p. $2.

WILLIAMS, FRANK, VILES, NELSON E ; and HAMON, RAY L. *School Housekeeping* Nashville, Tenn.: Interstate School Building Service, George Peabody College for Teachers, 1940. 16 p.

CHAPTER XIII. FUNCTIONS AND PREPARATION OF SCHOOL HEALTH PERSONNEL

AMERICAN ASSOCIATION OF TEACHERS COLLEGES, A DEPARTMENT OF THE NATIONAL EDUCATION ASSOCIATION. *The Student Personnel Policies and Practices of 151 Institutions Engaged in Teacher Education.* Oneonta, N. Y.: the Association (Sec.: Charles W. Hunt, Principal, State Normal School), 1940. Part I, 67 p. (Mimeo.)

AMERICAN ASSOCIATION OF VISITING TEACHERS. *Visiting Teacher Service Today.* San Diego, Calif.: the Association (Sec.: Mary Nicholls, Bureau of Child Guidance, City Schools), 1940. 21 p. (Planographed.)

AMERICAN JOURNAL OF PUBLIC HEALTH. "Educational Qualifications of Health Officers." *American Journal of Public Health* 29. 1342-43; December 1939. Available in reprint form.

BLACK, GEORGE H. *Teaching Health to Student Teachers* School Health Monograph No. 6. New York: Metropolitan Life Insurance Co. 13 p Free.

BLACK, GEORGE H, and OTHERS. *Health Programs in Professional Schools for Teachers.* School Health Monograph No. 8. New York: Metropolitan Life Insurance Co. 47 p. Free.

KANSAS CITY PUBLIC SCHOOLS. *A Manual for School Nurses.* Kansas City, Mo.: Board of Education, 1940. 72 p. (Mimeo.)

KEENE, CHARLES H. *The Physical Welfare of the School Child.* Boston: Houghton Mifflin Co., 1929. 505 p. $2.40

NATIONAL EDUCATION ASSOCIATION and AMERICAN MEDICAL ASSOCIATION, JOINT COMMITTEE ON HEALTH PROBLEMS IN EDUCATION. *The Nurse in the School* Washington, D. C.: the National Education Association, 1941. 40 p. 20¢.

PHAIR, J. T.; ROBERTS, R. H.; and POWER, MARY. *A Summer Course in Health Education.* School Health Monograph No. 11. New York: Metropolitan Life Insurance Co. 32 p. Free.

SPENCER, MARY E., and DOWELL, ANITA S. *Health Education in the State Teachers College at Towson, Maryland.* School Health Monograph No. 9. New York: Metropolitan Life Insurance Co. 55 p. Free.

SPOCK, BENJAMIN. "The Changing Task of the School Physician." *Progressive Education* 16: 576-81; December 1939. Available in reprint form

TERMAN, LEWIS M., and ALMACK, JOHN C. *The Hygiene of the School Child* Boston: Houghton Mifflin Co., 1929. 505 p. $2.50.

CHAPTER XIV. ADMINISTRATIVE PRACTICES AFFECTING THE HEALTH OF THE SCHOOL PERSONNEL

AMERICAN MEDICAL ASSOCIATION, BUREAU OF MEDICAL ECONOMICS. *Group Hospitalization.* Chicago: the Association, 1937. 296 p. 75¢.

NATIONAL EDUCATION ASSOCIATION, COMMITTEE ON TENURE. *Married Women Gainfully Employed.* Washington, D. C.: the Association, 1940. 32 p. 25¢.

NATIONAL EDUCATION ASSOCIATION, COMMITTEE ON TENURE *Teachers' Contracts: With Special Reference to Adverse Conditions of Employment.* Washington, D. C.: the Association, 1936. 32 p. 15¢.

NATIONAL EDUCATION ASSOCIATION, COMMITTEE ON THE ECONOMIC STATUS OF THE RURAL TEACHER. *The Economic Status of Rural Teachers.* Washington, D. C.: the Association, 1938. 32 p. 25¢.

NATIONAL EDUCATION ASSOCIATION, DEPARTMENT OF CLASSROOM TEACHERS. *Fit To Teach.* 9th Yearbook. Washington, D. C.: the Association, 1938. 276 p $1.

NATIONAL EDUCATION ASSOCIATION, NATIONAL COUNCIL ON TEACHER RETIREMENT. *Avocations of Retired Teachers.* Washington, D. C : the Association, 1941. 24 p. 25¢.

NATIONAL EDUCATION ASSOCIATION, RESEARCH DIVISION. "Administrative Practices Affecting Teacher Personnel" *Research Bulletin,* March and May 1942. (In process.)

NATIONAL EDUCATION ASSOCIATION, RESEARCH DIVISION. "Status of Teacher Retirement" *Research Bulletin* 19: 1-64; January 1941. 25¢.

NATIONAL EDUCATION ASSOCIATION, RESEARCH DIVISION. "The Teacher Looks at Teacher Load." *Research Bulletin* 17: 221-76; November 1939. 25¢.

NATIONAL EDUCATION ASSOCIATION, RESEARCH DIVISION. "The Teacher's Economic Position." *Research Bulletin* 13: 163-270; September 1935. 50¢.

CHAPTER XV. COORDINATION OF HEALTH AGENCIES

AMERICAN MEDICAL ASSOCIATION, BUREAU OF MEDICAL ECONOMICS. *Rural Medical Service.* Chicago: the Association, 1937 80 p. 15¢.

AMERICAN PUBLIC HEALTH ASSOCIATION. *Community Organization for Health Education.* Cambridge, Mass.: the Association, 1941. 120 p. 9¢

ASSOCIATION FOR CHILDHOOD EDUCATION *National Council of Childhood Education.* Washington, D. C.: the Association, 1941. 32 p (Mimeo.) 15¢.

AUERBACH, MURRAY A. *Programs for Local Tuberculosis Associations.* Administrative Series, No 4. New York: National Tuberculosis Association, 1937. 67 p.

BRITTEN, ROLLO H. "The National Health Survey." *Public Health Reports* 55: 2199-2224; November 29, 1940. Federal Security Agency, U. S. Public Health Service. Washington, D. C.: Government Printing Office, 1940. 5¢.

CARRIS, LEWIS H. *Preventing Blindness Through Social Hygiene Co-operation.* Publication 138. New York: National Society for the Prevention of Blindness, 1934. 11 p. 10¢.

CARRIS, LEWIS H., and MERRILL, ELEANOR B. *The Role of the Social Worker in a Prevention of Blindness Program.* Publication 258. New York: National Society for the Prevention of Blindness, 1937. 8 p 5¢.

CHILD WELFARE LEAGUE OF AMERICA. *A Health Program for Children in Foster Care.* New York. Child Welfare League of America, 1938. 24 p. 35¢.

CHILD WELFARE LEAGUE OF AMERICA *Standards for Child Protective Organizations.* New York. Child Welfare League of America, 1937. 15 p 25¢.

HAYDEN, AUDREY M. *Organization of Social Forces for Prevention of Blindness* Publication 275. New York. National Society for the Prevention of Blindness, 1938. 11 p. 10¢.

NATIONAL DENTAL HYGIENE ASSOCIATION. *Community Committees for Dental Health.* Washington, D. C.: the Association, 1941. 21 p. Free.

NATIONAL EDUCATION ASSOCIATION and AMERICAN MEDICAL ASSOCIATION, JOINT COMMITTEE ON HEALTH PROBLEMS IN EDUCATION. *Home and School Cooperation for the Health of School Children* Washington, D C . the National Education Association, 1937. 32 p 20¢

ROGERS, JAMES F. *Supervision of Health and Physical Education as a Function of State Departments of Education* Federal Security Agency, U. S. Office of Education, Bulletin 1940, No. 6. Washington, D. C.: Government Printing Office, 1941. 106 p. 15¢.

Shepard, W. P. "The Trained Worker Goes to Work." *American Journal of Public Health* 29: 1313-17; December 1939. Available in reprint form.

U. S. Department of Labor, Children's Bureau. *Community Social Services for Children* Folder 7 (Revised). Washington, D. C.: Government Printing Office, 1939. 11 p. 5¢

U. S. Department of Labor, Children's Bureau. *Conference on Children in a Democracy: Papers and Discussions at the Initial Session* Washington, D. C.: Government Printing Office, 1939. 149 p. 20¢

U. S. Department of Labor, Children's Bureau. *Health and Medical Care for Children* Separate from Preliminary Statements Submitted to the White House Conference on Children in a Democracy. Washington, D. C.: Government Printing Office, 1940. p. 163-206. Free.

Walker, W. Frank, and Randolph, Caroline R. *School Health Services*. New York: Commonwealth Fund, 1941. 198 p. $1.50.

Welch, Kathryn H. *The Meaning of State Supervision in the Social Protection of Children* U. S. Dept. of Labor, Children's Bureau Publication No. 252. Washington, D. C.: Government Printing Office, 1940. 22 p. 5¢.

CHAPTER XVI LEGISLATIVE AND LEGAL ASPECTS OF THE SCHOOL HEALTH PROGRAM

American Medical Association, Bureau of Medical Economics. *Medical Relations Under Workmen's Compensation* Chicago: the Association, 1938. 40 p.

American Medical Association, Bureau of Medical Economics. *Sickness Insurance Catechism.* Chicago: the Association, 1938. 13 p. 5¢.

Edwards, Newton. *The Courts and the Public Schools.* Chicago: University of Chicago Press, 1933. 591 p. $5.

Morrison, Henry C. *The Curriculum of the Common School.* Chicago: University of Chicago Press, 1940. 681 p. $4.

National Education Association, Research Division, Safety Education Projects. *Teacher Liability for Pupil Injuries.* Washington, D. C.: the Association, 1940. 24 p. 25¢.

Rogers, James F. *State-Wide Trends in School Hygiene and Physical Education* Federal Security Agency, U. S. Office of Education, Pamphlet No. 5 (Revised) Washington, D. C.: Government Printing Office, 1941. 15 p. 5¢.

Rosenfield, Harry N. *Liability for School Accidents.* New York: Harper and Brothers, 1940. 220 p. $2.

Russell, John D., and Judd, Charles H. *The American Educational System* Boston: Houghton Mifflin Co., 1940. 554 p. $2.25.

Smiley, D. F. "An Approach to the Problem of School Medical and Dental Service." *Journal of the American Medical Association* 108: 435-39; February 1937. Available in reprint form.

Tobey, James A. *Public Health Law.* New York: Commonwealth Fund, 1939. 414 p. $3.50.

Trusler, Harry R. *Essentials of School Law.* Milwaukee, Wis.: Bruce Publishing Co., 1927. 478 p. $6.

APPENDIX

Methods of Appraisal in School Health Programs

Organizations with Materials and Services of Use in Health Education

Speech Clinics and Institutions Offering Speech Correction Training

METHODS OF APPRAISAL IN SCHOOL HEALTH PROGRAMS

The following list of tests, checklists, and appraisal forms is representative of the types of measuring instruments available in health education. The inclusion or the omission of a test title does not indicate either the Commission's approval or disapproval. The chief purpose has been to provide a practical and readily accessible list of test material.

The present list consists of four parts: (a) checklists, records, and tests of physical status and ability; (b) checklists of buildings, equipment, and health programs; (c) tests of health knowledge; and (d) tests of attitudes, personality, character, and social behavior.

Where personal direction with respect to the selection and use of tests is not available, teachers should consult the *Mental Measurements Yearbook, 1940,* edited by Oscar K. Buros (Highland Park, N. J., 1941, 674 p.). Earlier summaries were prepared beginning in 1933. Help may also be obtained from issues of the *Review of Educational Research* (February 1933, December 1935, and December 1938) published by the American Educational Research Association. Various books on testing should be consulted, such as *Tests and Measurements in Health and Physical Education* by Charles H. McCloy (New York: F. S. Crofts and Co., 1939, 392 p.).

Comment on the Use of Measurements

Except for practice or experimental purposes, the various types of appraisal instruments suggested in the present list should not be used by persons who are untrained and inexperienced in the field of measurements. This warning is particularly important with respect to the tests listed under "Tests of Attitudes, Personality, Character, and Social Behavior." Here is an area where even experienced and competent persons disagree with respect to definitions, technics, and interpretations.

In most school situations, the classroom teacher, with little preparation in testing, will find the rating scales (Nos. 43, 46, 47, 49, 54, and 59) most readily useful These scales will help many teachers to become more observant of various qualities of pupil behavior which might ordinarily be overlooked. At the same time it should be remembered that most rating scales require the rater to express an *opinion* with respect to the existence or the quality of specific items. Some of these items are relatively trivial and many are intangible. The use of such rating scales calls for a great deal of common sense.

The self-rating scales for use by the pupils themselves should be used sparingly. Someone has said, "There is no more priggish practice than the practice of deliberate self-improvement." (Benjamin Franklin to the contrary notwithstanding!) Perhaps the greatest value may be in comparing an individual's self-rating with the opinions that his peers may have of him. The study of these reactions, when checked against other sources of data, will reveal clues as to individual personality development.

Most of the other instruments listed are attempts by indirect procedures to appraise attitudes and traits. Most of these tests are in an early stage of development. In many instances the tests strain the individual's intellectual honesty or confuse him by slippery terminology. Also, some tests (e.g., Nos. 39 and 58) carry labels implying that they are tests of neurotic and unstable characteristics. Any discussion of such terms may lead to misunderstandings among both teachers and parents. When any of these tests are used, it should be kept in mind that they are still relatively crude instruments, but the results when taken with other sources of information may be useful to a competent investigator.

Checklists, Records, and Tests of Physical Status and Ability

1. American Association for Health, Physical Education, and Recreation, a department of the National Education Association. "Physical Fitness (Springfield College Studies of Health and Physical Education)." *Research Quarterly* 12: 301-493; May 1941 (supplement).

   A review of a number of the research studies of body build, weight, posture, motor fitness, and similar evidences of physical condition.

2. Bovard, John F., and Cozens, Frederick W *Tests and Measurements in Physical Education.* Philadelphia. W. B. Saunders Co., 1938. 427 p.

   A comprehensive manual of measurement in physical education.

3. Cozens, Frederick W ; Cubberley, Hazel; and Neilson, N. P. *Achievement Scales in Physical Education Activities: For High School Girls and College Women.* New York: A. S Barnes and Co, 1937. 165 p.

   A series of measures of status and progress in the acquisition skills in physical activities.

4. Cozens, Frederick W.; Trieb, M. H.; and Neilson, N. P. *Physical Education Achievement Scales.* New York: A. S Barnes and Co., 1936. 155 p.

   Describes a number of physical activities for boys of secondary-school age and presents performance scores.

5. Eames, Thomas H. *Eames Eye Test.* Yonkers-on-Hudson, N. Y., World Book Co. Examiners Kit, $3.50.

   Prepared to help nurse or classroom teacher to screen out pupils probably requiring professional eye examination.

6. Franzen, Raymond. *An Evaluation of School Health Procedures.* (Published originally by the American Child Health Association, 1933.) Washington, D. C.: National Education Association. 127 p. Paper, 90¢; cloth, $1.15.

   A summary of test procedures and technics useful in determining health needs of children, personnel rapport, and effectiveness of supervisory practices

7. Jenss, Rachel M., and Souther, Susan P. *Methods of Assessing the Physical Fitness of Children.* U. S. Dept. of Labor, Children's Bureau. Washington, D. C.: Government Printing Office, 1940. 121 p

   A summary of the effectiveness of methods used in identifying unfit boys and girls. Based on experiences in New Haven, Connecticut.

8. National Education Association and American Medical Association, Joint Committee on Health Problems in Education. *Health Inspection of School Children.* Washington, D. C.: the National Education Association, 1933 24 p.

   Brief review of the physical factors to be checked in a minimum examination program.

9. Neilson, N. P., and Cozens, F. W. *Achievement Scales in Physical Education.* New York· A S. Barnes and Co , 1934. 171 p.

   Presents a procedure for classifying children into eight groups for instruction and participation in physical activities and games. For elementary and junior high schools.

10. Pryor, Helen B. *Width-Weight Tables.* Stanford University, Calif.: Stanford University Press. 15 p.

    A series of tables that may be used to predict body weight in terms of width of hips and width of chest as well as height for each age and sex. Includes age range one year to forty-one plus.

11. Wetzel, Norman C. "Physical Fitness in Terms of Physique, Development, and Basal Metabolism." *Journal of American Medical Association* 116: 1187-95; March 22, 1941

    Presents a standard grid form which, when used to plot development, indicates the status of physical health.

Checklists of Buildings, Equipment, and Health Programs

12. American National Red Cross. *Checklist for Common Hazards in and about the Home and on the Farm.* Washington, D. C.: American National Red Cross. 2 p.

    A list of some fifty questions on the conditions and equipment that often lead to accidents.

13. American Public Health Association. *Appraisal Form for Local Health Work.* New York. the Association, 1938

A compendium of practices and activities representing the desirable elements of a local (urban and rural) health program. Includes a section on school hygiene.

14. Dearborn, Terry H. *A Checklist for the Survey of Health and Physical Education Programs in Secondary Schools.* Stanford University, Calif.: Stanford University Press. 23 p.

A classified list of items pertinent to a school health program. Can be used to record the existence and status of equipment, procedures, and activities.

15. Engelhardt, N. L. *Standards for Junior High School Buildings.* New York: Teachers College, Columbia University, 1932. 161 p.

Reviews criteria with respect to health, safety, and sanitary factors in the planning of junior high schools.

16 Engelhardt, N. L.; Reeves, Charles E.; and Womrath, George F *Survey Data Book for Public School Janitorial-Engineering Service.* New York· Teachers College, Columbia University, 1932. 75 p.

An attempt to provide objective means for appraising the janitorial-engineering service of a school.

17. Illuminating Engineering Society and American Institute of Architects *American Recommended Practice of School Lighting* New York: the Society, 1938. 60 p.

A discussion of standards and problems with respect both to natural and artificial lighting. Prepared in cooperation with several associations interested in conservation of eyesight.

18. Linn, H H.; Helm, L C.; and Grabarkiewicz, K. P. *Checklist Forms for Rating School Custodial Service.* New York. Teachers College, Columbia University, 1940.

Fourteen checklists and explanation (2 pages) covering housekeeping in classrooms, toilets, swimming pools, and other areas of school plant.

19. Massachusetts Institute of Technology, Department of Biology and Public Health. *School Health Appraisal Form.* Cambridge, Mass.: the Institute, 1930. 73 p.

A constructive and suggestive guide for the study of school health programs. Part I for city schools; Part II for rural schools.

20. National Board of Fire Underwriters. *Self-Inspection Blank for Schools.* New York. the Board, 1938. 2 p.

A list of thirty-six items designed to encourage certain precautions against school fires.

21. National Council on Schoolhouse Construction. "Factors Pertinent to School Plant Planning." *Proceedings, 1940* Nashville, Tenn : the Council (Sec.: Ray L. Hamon, George Peabody College), 1941. p. 80-107

General standards on sites, construction, and equipment.

22. National Education Association, Research Division, Safety Education Projects. *Checklist of Safety and Safety Education.* Washington, D. C: the Association, 1939. 30 p.

A list of 214 items covering plant, equipment, and program as related to safety education

23 National Recreation Association. *Play Space in New Neighborhoods.* New York: the Association, 1939. 23 p.

A committee report of standards of outdoor areas in housing developments. The Association also issues standards for playground equipment.

24. National Recreation Association. *Schedule for the Appraisal of Community Recreation* New York. the Association.

Offers a means of measuring the degree to which cities are furnishing their people with well-rounded recreation opportunities.

25. Rogers, James F *Safety and Health of the School Child.* U. S. Dept of the Interior, Office of Education, Pamphlet No. 75 Washington, D C: Government Printing Office, 1937. 29 p.

A self-survey of school conditions and activities.

26 Strayer, George D, and Engelhardt, N L. *Standards for Elementary School Buildings.* New York. Teachers College, Columbia University, 1933 181 p.

A summary of criteria and principles with respect to site, building, service systems, and similar items including health-service rooms and sanitation

27. Strayer, George D., and Engelhardt, N L. *Standards for High School Buildings.* New York. Teachers College, Columbia University, 1924. 95 p

An outline of standards and score card covering various aspects of school building construction including health and sanitation features.

Health Knowledge Tests

28. American Child Health Association. *Health Education Test Forms.* (Published originally by the American Child Health Association, 1927) Washington, D. C · National Education Association.

Five types of tests of health knowledge.

29 Brewer, John, and Schrammel, H. E *Brewer-Schrammel Test of Health Knowledge and Attitude.* Emporia, Kans . Kansas State Teachers College. Specimen set, 15¢.

Aims to measure knowledge of facts and principles in healthful living and pupil attitudes toward health rules. For Grades IV thru VIII.

30 Franzen, Raymond. *Health Education Tests* (Published originally by the American Child Health Association, 1929) Washington, D. C.. National Education Association. 70 p. Paper, 60¢; cloth, 90¢.

A description of tests used in a school health study with norms for Grades V and VI.

31. Franzen, Raymond; Derryberry, Mayhew; and McCall, William A *Health Awareness Test.* New York Teachers College, Columbia University.

A test for measuring health information, attitudes, and habits. Designed for age range eight to sixteen years.

32. Gates, Arthur I., and Strang, Ruth. *Gates-Strang Health Knowledge Test* New York: Teachers College, Columbia University. Specimen set, 15¢.

    Based upon the facts found in twenty health courses in fourteen widely used textbooks on health. One form for Grades III thru VIII; forms also for Grades VII thru XII.

33. Gill, E. M., and Schrammel, H. E. *Gill-Schrammel Physiology Test.* Emporia, Kans.: Kansas State Teachers College. Specimen test, 15¢.

    Based upon material found in a number of leading textbooks in field of high-school physiology. For junior and senior high school.

34. Kilander, H. F. *Kilander Health Knowledge Test.* East Orange, N. J.: the Author (Panzer College of Physical Education and Hygiene).

    A test of 100 multiple-choice items in fields of nutrition, communicable disease, sanitation, safety and first aid, and social and mental health. For Grades XII and XIII.

35. Orleans, Jacob S., and Sealy, Glenn A. *Public School Achievement Tests. J. Health* Bloomington, Ill.: Public School Publishing Co

    A test of knowledge of health facts for use from Grades IV thru VIII Four forms available.

36. Speer, Robert K., and Smith, Samuel. *Health Test.* National Achievement Tests Rockville Center, N. Y.: Acorn Publishing Co.

    Designed to test knowledge of health facts, judgment, and appreciation Two forms available for Grades III thru VIII.

37. Trusler, V. T., Arnett, C. E.; and Schrammel, H. E *Trusler-Arnett Health Knowledge Test* Emporia, Kans.: Kansas State Teachers College Specimen set, 15¢.

    Designed to measure the student's knowledge of the basic facts, principles, and rules fundamental to healthful living For Grades IX thru XII and college

Tests of Attitudes, Personality, Character, and Social Behavior

38. Bell, Hugh M. *Adjustment Inventory.* Stanford University, Calif.: Stanford University Press. Specimen set, 15¢

    A personality questionnaire of 140 items providing scores on home, health, and social and mental adjustment. For Grade IX thru college; also an adult form

39. Bernreuter, Robert G. *Personality Inventory.* Stanford University, Calif.: Stanford University Press Specimen set, 25¢.

    A questionnaire test designed to yield measures of neurotic tendency, self-sufficiency, introversion-extroversion, dominance-submission, self-confidence, and sociability. For Grade IX thru college.

40. Brown, Fred *Personality Inventory for Children.* New York. Psychological Corporation. Specimen set, 15¢.

    An inventory of eighty items within the categories of home, school, physical symptoms, insecurity, and irritability. For ages nine to fourteen years.

41. Byrd, Oliver E. *Byrd Health Attitude Scale.* Stanford University, Calif.: Stanford University Press.

    A list of 100 statements intended to measure health attitudes of individuals. For senior high school and first two years of college.

42. Champney, Horace. *Fels Parent-Behavior Rating Scales.* Yellow Springs, Ohio: Antioch Press. Specimen set, 25¢.

    For use of trained home visitor in appraising certain parent-child relationships.

43. Cornell, E. L.; Coxe, W. W.; and Orleans, J. S *New York Rating Scale for School Habits* Yonkers-on-Hudson, N. Y.: World Book Co. Per package, 50¢.

    A record of character traits designed to indicate future success in schoolwork.

44. Cowan, Edwina A *Cowan Adolescent Personality Schedule.* Wichita, Kans.: Wichita Child Research Laboratory. Specimen set, 50¢.

    An instrument providing scores on items such as fear, family emotion, family authority, inferiority, escapes, and compensation. For ages twelve to eighteen.

45. Downey, June E. *Downey Will-Temperament Test.* Yonkers-on-Hudson, N Y.: World Book Co. Specimen set, individual test, 25¢; group test, 20¢

    Prepared both as an individual and a group test. Designed to determine temperamental traits thru a series of motor reactions recorded chiefly thru writing.

46. Haggerty, M. E.; Olson, W. C.; and Wickman, E. K. *Haggerty-Olson-Wickman Behavior Rating.* Yonkers-on-Hudson, N. Y.: World Book Co Specimen test, 10¢.

    Includes in Schedule A a behavior problem record, in Schedule B a behavior rating scale for intellectual, physical, social, and emotional traits

47. Hayes, M. L. *Scale for Evaluating the School Behavior of Children.* New York: Psychological Corporation

    A scale intended to help teachers analyze the habits of adolescents as a basis for discovering maladjustments and developmental needs. For ages ten to fifteen years.

48. Hildreth, Gertrude *Personality and Interest Inventory.* New York: Teachers College, Columbia University. Specimen sets, elementary 10¢; high school 15¢.

    A questionnaire approach to interests in activities, games-sports, school subjects, books, and so forth. For Grades IV thru IX and IX thru XII.

49. Joel, Walther, and Joel, Janet. *Behavior Maturity Rating Scale for Nursery School Children* Los Angeles. the Authors (City College). Single test, 5¢.

    For use with children one and one-half to six years of age.

50. Lewerenz, Alfred S., and Steinmetz, Harry C. *Orientation Test Concerning Fundamental Aims of Education.* Los Angeles: California Test Bureau. Specimen set, 15¢.

    Designed to measure beliefs likely to condition attitudes. Contains section on physical and mental health items. For high school and college.

51. Link, Henry C., and others. *P.Q. or Personality Quotient Test* New York: Psychological Corporation. Specimen set, 25¢.

    Attempts to measure extroversion, social aggressiveness, self-determination, economic self-determination, and adjustment to the opposite sex. For Grades VII thru XIII.

52. McFarland, Ross A., and Seitz, C. P. *P-S Experience Blank.* New York: Psychological Corporation. Specimen set, 25¢.

    An inventory of 92 questions designed to select those who exhibit excessive psychoneurotic tendencies. For late adolescence and adults.

53. Maller, J. B. *Case Inventory.* New York: Teachers College, Columbia University. Specimen set, 30¢.

    A personality schedule yielding scores on emotionalized responses, adjustments, honesty, and ethical judgment and integration. For Grades V thru XII.

54. Maller, J. B. *Character and Personality Rating Scale* New York: Teachers College, Columbia University. Specimen set, 25¢.

    A scale of 50 items divided equally under two parts: character and personality. Includes items on sense of humor, responsiveness, neatness, social-mindedness, and so forth

55. Pressey, S. L., and Pressey, L. C. *Pressey Interest-Attitude Tests.* New York. Psychological Corporation. Specimen set, 15¢.

    A test of things the individual is interested in, worries about, considers wrong, and admires in people. For Grade VI thru adults.

56. Remmers, H. H. *Attitude Scales.* Lafayette, Ind.: Division of Educational Reference, Purdue University. Twelve scales, specimen set of each, 15¢.

    Generalized attitude scales designed to measure attitudes toward disciplinary procedures, play, teachers, social action, and so forth. For Grade VII thru college.

57. Stodgill, Ralph M. *Behavior Cards.* Columbus, Ohio: the Author (2280 W. Broad Street). Testing outfit, $2 25.

    A test-interview form for delinquent children. May be used with those having a reading grade score of 4.5 or higher.

58. Thurstone, L. L., and Thurstone, Thelma G *Thurstone Personality Schedule* Chicago: University of Chicago Press Specimen set, 15¢.

    A questionnaire designed to obtain an index of neurotic tendencies. For college students and adults.

59. Van Alstyne, D. *Winnetka Scale for Rating School Behavior.* Winnetka, Ill.: Winnetka Educational Press. Single copy, 10¢.

    A scale of 13 classroom situations used to score a pupil's assets with respect to cooperation, social consciousness, emotional security, leadership, and responsibility. For nursery school thru Grade VI.

60. Washburne, John N. *Washburne Social-Adjustment Inventory.* Yonkers-on-Hudson, N. Y.: World Book Co. Specimen set, 15¢.

    A test to discover and diagnose cases of maladjustment among students in secondary schools and colleges.

ORGANIZATIONS WITH MATERIALS AND SERVICES OF USE IN HEALTH EDUCATION

Educators should be acquainted with the sources of aid and information available in the field of health education. Many of these are local and state agencies which have not been included in the following list. The purpose of the present listing is to indicate the general nature of the activities of certain national organizations Some of these are projects of the federal government; others are commercial agencies; and many are professional associations.

The descriptive statements included have been submitted to officials of each agency for verification. Neither the omission of any organization from the list nor the presentation of any statement is intended to convey the official approval or disapproval of the American Association of School Administrators.

This list is grouped into three major divisions: (a) the National Education Association and its departments, (b) private agencies, and (c) federal governmental agencies.

National Education Association Agencies

1. American Association for Health, Physical Education, and Recreation, a department of the National Education Association. 1201 Sixteenth Street, N. W, Washington, D. C. Address. N. P. Neilson, executive secretary.

A professional organization for workers in health, physical education, and recreation in schools, colleges, and community and private organizations Provides consultation service, field service, and general information service, also conducts national and district conventions, works with state and local health, physical education, and recreation organizations, and publishes two magazines. the *Journal of Health and Physical Education* (monthly except July and August), and the *Research Quarterly* (published March, May, October, December).

2. American Association of School Administrators, a department of the National Education Association. 1201 Sixteenth Street, N. W, Washington, D. C. Address: S. D. Shankland, executive secretary.

Thru its conventions and exhibits the Association offers school administrators many opportunities to become informed as to current health education problems and as to available health instructional materials In 1940, issued the yearbook *Safety Education* ($2) which is a comprehensive treatment of both principles and practices. In cooperation with the NEA Research Division, maintains the Educational Research Service (subscription $25 a year) as a clearing-house of information on school administration.

3. International Council for Exceptional Children, a department of the National Education Association. Address. Samuel A. Kirk, president, State Teachers College, Milwaukee, Wis.

   An organization of about 5000 educators engaged or interested in the promotion and welfare of the education of exceptional children—the handicapped and the gifted Publishes the *Journal of Exceptional Children* (eight times a year).

4. National Education Association. 1201 Sixteenth Street, N. W., Washington, D. C. Address· Willard E Givens, executive secretary.

   Contributes to health education in the following ways· by sponsoring a joint committee with the American Medical Association (see item 5); thru cooperation with its departments in certain fields (e.g., American Association for Health, Physical Education, and Recreation, see item 1); thru the distribution of publications formerly published by the American Child Health Association; and thru the publication of bibliographies, lesson units, and other materials in the field of safety education Among its outstanding publications in the field of health education are *Fit To Teach* and *Health Education.* A free list of publications will be sent upon request. Publishes the *Journal of the National Education Association,* which contains an occasional article or bibliography dealing with health education ($2 a year, free to members)

5. National Education Association and American Medical Association, Joint Committee on Health Problems in Education. Address: Charles C. Wilson, M.D., chairman, 525 West 120th Street, New York, N. Y.

   Fosters a closer understanding between educators and physicians in order that each group may make the maximum contribution to the solution of health problems; studies the relationship of physicians and educators to health problems, to each other, and to other agencies; conducts symposiums on school health problems in conjunction with annual meeting of the American Association of School Administrators and annual meeting of the American Medical Association Publications, available from either National Education Association or American Medical Association, include (a) *Health Education,* (b) *Health Inspection of School Children,* (c) *Home and School Cooperation for the Health of School Children,* (d) *Mental Hygiene in the Classroom,* (e) *Mouth Health of School Children,* (f) *The Nurse in the School,* (g) *Open Air Classrooms,* and (h) *School Health Policies.*

6. National Education Association, Department of Home Economics. 1201 Sixteenth Street, N. W , Washington, D. C Address· Clara Lee Cone, president.

   Promotes "the growth and progressive development of home economics education in the public-school program " Since one of the primary objectives of home economics education is the improved physical and mental health of the individual and the family group, the Department has a definite responsibility for promoting this objective. The goal of health is emphasized in committee activities, in the two yearly meetings of the Department, in American Education Week folders published every year, and in joint publications with other educational organizations. Cooperates actively with the national nutrition program for defense

7. National Education Association, Department of Lip Reading. Address: Dorothy Vernon, secretary, 1331 North 24th Street, Birmingham, Ala.

An organization of teachers of lip reading with these purposes: to work unitedly for better understanding of problems of people with imperfect hearing in relation to their education and rehabilitation thru skill in lip reading; to improve methods of such instruction; to raise standards for requirements of teachers of lip reading; and to cooperate in furthering the interests of children and adults with impaired hearing. Publishes bulletin *The Lip Reader* (three issues yearly).

8. National Education Association, Department of Special Education. (Now the International Council for Exceptional Children; see item 3.)

Private Agencies

9. Allied Youth, Inc. 1201 Sixteenth Street, N. W., Washington, D. C. Address: W. Roy Breg, executive secretary.

By field service and printed materials, organizes and serves youth-led, school-sponsored Posts of Allied Youth, which specialize in alcohol education and alcohol-free recreation. Services of the national movement to high schools and Allied Youth Posts include: *The Allied Youth* (monthly except August), attractively written and illustrated health facts and related materials for young people; *Alcoholfax Educational Service* (monthly during school year), loose-leaf bulletins and pamphlets of fact and program helps on alcohol education and related subjects; manuals for organizing Post program and conducting educational and recreational activities; basic books and pamphlets on health phases of the use of alcohol and other topics related to youth welfare; visits of field representative, addressing high-school assembly and assisting students to organize an educational and recreational program of Allied Youth. The movement is counseled by numerous specialists in the fields of physical and mental health, also by coaches, educators, and youth leaders.

10. American Academy of Pediatrics, Inc. 636 Church Street, Evanston, Ill. Address: Clifford G. Grulee, M.D., secretary.

Organized for the promotion of child health and child welfare in the United States and Canada. It has a membership of approximately 1350 pediatricians. It cooperates with lay and medical organizations having the same objectives thru committees, both national and state. Interested especially in the general health of children, their protection in the home and in school. Issues pamphlets for physicians and laity; sponsors the publication of the *Journal of Pediatrics* (monthly).

11. American Association of Medical Social Workers. 844 Rush Street, Chicago, Ill. Address: Mary M. Maxwell, executive secretary.

Serves as an organ of intercommunication among medical social workers; maintains and improves standards of social work in hospitals, dispensaries, special clinics, or other distinctly medical or psychiatric institutions; and stimulates its intensive and extensive development. Has a membership of about 2000; is organized into thirteen districts in the United States and Canada. Issues a *Bulletin* eight times a year. Nonmembers pay a subscription fee of $1.

12. American Association of Psychiatric Social Workers. 1790 Broadway, New York, N. Y.

A national professional association of approximately 550 psychiatric social workers employed in psychiatric hospitals and clinics or in social and mental hygiene work in other social agencies. Organized to study, maintain, and promote professional standards in psychiatric social work, such as methods of practice, professional education, and government and civil service developments; to foster relationships with other professional associations and agencies; and to give opportunity for interchange among members. The *News-Letter,* published quarterly by the Association, is largely devoted to articles, editorials, and book reviews of a technical nature dealing with practice, education, standards, or studies in psychiatric social work. Other publications represent, in the majority, studies and reports of the Association's committees. The book *Psychiatric Social Work,* by Lois Meredith French, published in 1940 by the Commonwealth Fund, is the outcome of a research study on trends in psychiatric social work, fostered by the Association.

13. American Association on Mental Deficiency, Inc Address: E. Arthur Whitney, M.D., secretary, Elwyn, Delaware County, Pa.

Organized in 1876, incorporated in 1938, for the study of all forms of mental retardation. Chief among its objectives are mental examination for all backward children; a complete census and registration of all mentally retarded children; special classes for the subnormal in public schools; increased institutional facilities for the lower grades of mental defect; selective sterilization for the hereditary types; special provision for the "defective delinquent"; and thoro research into the causes, cure, prevention, instruction, care, and general welfare of the subnormal. Meets annually and has regional meetings besides the annual. Publishes the *American Journal of Mental Deficiency* as a quarterly. Physicians, psychologists, teachers, parole officers, social workers, and interested laymen are eligible for membership.

14. American Association To Promote the Teaching of Speech to the Deaf. 1537 35th Street, N. W., Washington, D. C. Address. Josephine B Timberlake, executive secretary.

Assists schools for the deaf in their efforts to teach speech and lip reading, provides information for parents of deaf children, and maintains a reference library and information service on deafness and those handicapped by deafness of any degree. Controls the Volta Bureau for the increase and diffusion of knowledge relating to the deaf Publishes *Volta Review,* monthly, $2 a year, *Biennial Proceedings,* $1 a copy.

15 American Camping Association, Inc 330 South State Street, Ann Arbor, Mich. Address· Ross L. Allen, executive director.

Recognizes the maintenance and improvement of health in campers as a primary objective of the camping experience for children and adults. Holds conferences and workshops and initiates studies and research on health aspects of camping. Attempts to have camp leaders recognize the great potentialities for health administration in the camp situation. Publishes health education articles in its official publication, the *Camping Magazine* (nine issues yearly) Discusses health education in camp at its sectional and national meetings Consultation service on health education problems, bibliographical and book loan service.

16. American Council on Education 744 Jackson Place, Washington, D. C Address· George F. Zook, president.

Sponsors research programs and service activities of special concern to education. The American Youth Commission has studied health programs in colleges and universities, the National Youth Administration, and CCC camps, and has published two volumes dealing with these studies The Commission on Teacher Education of the Council is also concerned with mental and physical health programs with respect to both students and teachers

17. American Dental Association 212 East Superior Street, Chicago, Ill Address Harry B. Pinney, secretary.

Cultivates and promotes the art and science of dentistry; elevates and sustains the professional character and education of dentists; and enlightens and directs public opinion in relation to oral hygiene, dental prophylaxis, and advanced scientific dental service. These activities are carried on chiefly thru various bureaus and commissions such as the Research Commission, Library Bureau, Bureau of Economics, Bureau of Legislation, Council on Dental Education, Council on Dental Therapeutics, and the Bureau of Public Relations The last two of these furnish information on dental medicaments and care of the mouth to the public. Maintains a library service for members and publishes the *Journal of the American Dental Association* (monthly).

18. American Dietetic Association. 185 North Wabash Avenue, Chicago, Ill. Address: Gladys E. Hall, educational director.

A professional organization of 5000 members who are mainly hospital dietitians, nutritionists for state and local agencies (public and private), consultant dietitians, college teachers of nutrition and related subjects, food service directors in residence halls, cafeteria directors in schools and colleges, restaurant managers, research workers, and food editors. Placement bureau service is available to members A collection of material used by dietitians and nutritionists is on file and available to responsible persons. Publishes *Journal of the American Dietetic Association* (ten issues yearly, twelve issues yearly beginning January 1942).

19 American Eugenics Society, Inc. RKO Building, Rockefeller Center, New York, N Y Address: Rudolf C. Bertheau, secretary.

The national organization devoted to the whole problem of improving the quality of the American people It is an educational membership society consisting of, and directed by, scientists, professionals, and laymen who, thru active membership, are aiding in the development of a sound, democratic eugenics program. To this end the Society serves as a center of authentic information and guidance in this problem for agencies working in fields for the advancement of family life, general social welfare, health, and education; encourages research in human heredity, environment, and population problems; promotes a soundly informed public opinion thru its own publications and meetings and thru general channels of public education, including courses in colleges and senior high schools on family life and human relations, and stimulates the medical profession and public health authorities to their proper responsibility for reducing the incidence of hereditary defect.

20 American Foundation for the Blind, Inc 15 West 16th Street, New York, N Y. Address: Robert B. Irwin, executive director.

Promotes the interests of the blind thru the United States in close cooperation with all local organizations thru the following activities: research, consultation service; field service in state and community; service to blind individuals; publication of professional literature; reference and lending library service; study of vocational opportunities for the blind; and National Industries for the Blind. Publishes four magazines: *Outlook for the Blind* (five times a year in Braille and inkprint), *The Teachers Forum for Instructors of Blind Children* (five times a year in Braille and inkprint); *Talking Book Topics* (quarterly in inkprint and phonographic record form); *Braille Book Review* (monthly in Braille)

21. American Genetic Association. 308 Victor Building, 724 Ninth Street, N. W., Washington, D. C. Address. C. E. Leighty, secretary.

Devoted to the increase and diffusion of knowledge regarding heredity, the program of this Association has important implications for a comprehensive health program. It has long been known that a number of rare diseases, such as hemophilia, have a genetic basis. More recently it has been discovered that much more widespread menaces to health also have definite genetic components. Thus recent studies have shown that rheumatic fever, one of the most widespread and destructively crippling diseases of childhood, is conditioned in its expression by a single recessive gene. Those children who come down with rheumatic fever do so because of their hereditary constitution. Diabetes is another disease which, in spite of insulin therapy, still has important genetic implications. The publications of the Association discuss during the year many angles of surpassing importance in the development of such a program. In the field of positive eugenics, the question of encouraging increased reproduction among those couples endowed with better-than-average health of body and mind also must receive increasing consideration in a well-rounded program of health conservation. The Association carries on its extension work thru the publication of the monthly *Journal of Heredity* (subscription, $3.50 a year). Pamphlets, charts, and other literature are available, some free and some for which a price list will gladly be furnished.

22. American Heart Association, Inc. 1790 Broadway, New York, N. Y.

Focuses attention chiefly upon the collection and correlation of facts relating to heart disease; the devising and application of preventive measures to lessen impairment of the heart; the coordination of the work being done in established centers in the fight against heart disease; the encouragement and assistance requisite for development of additional centers for cardiac work; the dissemination of information in regard to heart disease and the methods to be employed for its prevention and relief; and the arousing of the public mind to its responsibility and opportunity to assist in the fight against heart disease Publishes and distributes a quarterly bulletin; a monthly leaflet entitled *Modern Concepts of Cardiovascular Disease;* a small volume, *Nomenclature and Criteria for Diagnosis of Diseases of the Heart;* booklets upon *Standard Requirements for a Cardiac Clinic* and *Standard Requirements for a Peripheral Vascular Disease Clinic;* pamphlets on various phases of heart disease; cardiac record charts for use in hospital out-patient clinics; educational films and lantern slides. The *American Heart Journal,* published monthly, is the leading journal of the world in its particular field and is under the editorial direction of this Association.

23. American Home Economics Association. 620 Mills Building, Washington, D. C. Address: Edna Van Horn, executive secretary.

Brings together persons trained in home economics or related fields, both those gainfully employed and individual homemakers; seeks to develop and promote standards of home and family life that will best further individual and social welfare. The work of members in all divisions of the home economics field contributes to health and health education, especially perhaps thru child guidance and nutrition, including the educational values of the school lunch. The Association has a standing committee on home economics in health education which promotes community cooperation between home economists and others concerned with improving home and family life. Publishes a professional magazine, the *Journal of Home Economics* (ten issues yearly); *National Magazine of Home Economics Student Clubs* (four issues yearly); *Consumer Education Service;* a few books and bulletins; and special papers on topics bearing on health education.

24. American Institute of Family Relations. 607 South Hill Street, Los Angeles, Calif. Address: Paul Popenoe, general director

Promotes education for successful marriage and family life by lectures before schools, teachers' organizations, and parents' organizations; a correspondence course in the technic of counseling, for teachers, social workers, and others called on to deal with individual problems involving sex, heredity, love, marriage, parenthood, and the general fields of social and mental hygiene. Offers use of a circulating library in its field; helps teachers and others to get syllabuses and teaching material; assists in research and advises on curriculums; publishes about seventy-five pamphlets dealing with various phases of family relations.

25. American Junior Red Cross. National Headquarters, Washington, D. C. Address: James T. Nicholson, national director.

Makes available to schools, for specialized health instruction, courses of the American National Red Cross in first aid, water safety, food selection, and home nursing, for those classes or other groups the members of which are old enough to be eligible for certification. Emphasizes in its *Activities Calendar* of program suggestions "physical and mental fitness" for meeting social responsibility and includes, in the magazines for elementary and secondary schools, reports, articles, and illustrations developing the same emphasis. These health education materials developed currently are received by schools enrolled in the American Junior Red Cross (see item 29).

26. American Library Association. 520 North Michigan Avenue, Chicago, Ill Address: Carl H. Milan, executive secretary.

Among its activities in promoting library service it keeps libraries and individuals informed concerning health education materials published in book or pamphlet form. This is done thru the annual selected list, *Health Books for Public Libraries,* which is included each spring in *The Booklist;* by the health education books described in this semimonthly guide to new books; and thru many other bibliographies of material for children and for adults. The following series of health booklets prepared by a joint committee of the American Library Association and the American Medical Association are available (only in units of 100) from the American Library Association at $1 for 100 copies Titles: *Food, Personal Health, Infants, The Child, Sex and Marriage, Mental Health, Medicine, Diseases, Public Health.*

27. American Medical Association, Bureau of Health Education. 535 North Dearborn Street, Chicago, Ill. Address: W W. Bauer, M D., director.

Professional organization of physicians in the United States, publishes weekly journal and nine special journals for physicians; publishes *Hygeia, The Health Magazine* for lay readers; broadcasts dramatized radio health programs in season on NBC network; participates in consultant and committee work with other professional and lay organizations; answers letters from lay inquirers not involving diagnosis or treatment; publishes pamphlets at nominal prices and a few posters; furnishes limited number of exhibits for national or statewide meetings educational in character; price list of publications free on request and limited number of samples to teachers when requested on letterhead of school system, furnishes speakers for national, statewide, or large local meetings; supplies bibliographies.

28 American Medical Association, Bureau of Medical Economics. 535 North Dearborn Street, Chicago, Ill. Address· R. G. Leland, M D., director.

Conducts special studies, makes analyses of arrangements proposed or in operation, and collects source material pertaining to the various methods by which medical services are made available to the public. Among the Bureau publications are. *University and College Student Health Service, State Education and State Medicine, Organized Payments for Medical Services, Group Hospitalization, A Critical Analysis of Sickness Insurance, Health Insurance in England, Rural Medical Service, Factual Data on Medical Economics, Handbook of Sickness Insurance, State Medicine and the Cost of Medical Care,* and *Distribution of Physicians in the United States.*

29 American National Red Cross. National Headquarters, Washington, D. C. Address: Norman H. Davis, chairman

Thru the following services, operates in the field of health· instruction in first aid, water safety, accident prevention, home nursing, and nutrition; the enrolment of properly qualified nurses for emergency service, the enrolment of properly qualified medical technologists, at the request of the surgeon general of the Army, for emergency service, the conduct of public health nursing services in rural and semirural districts where such services do not exist, the promotion of educational activities for children thru membership in the Junior Red Cross; extension of medical relief in disasters or other emergencies; extension of medical, nursing, and related services to members, or disabled former members, of the armed forces, and their dependents; special projects in the field of blood procurement, enrolment of doctors for the British Red Cross, and the study of rehabilitation of Selective Service men with remediable defects. Materials and personnel to assist school health educational programs should be requested thru local chapters of the Red Cross Publishes the *Red Cross Courier* (monthly)

30 American Occupational Therapy Association. 175 Fifth Avenue, New York, N. Y. Address: Mrs. Meta R. Cobb, executive secretary.

Promotes the use of occupational therapy, advances the standards of education and training in the field, promotes research, and engages in other activities which may be considered advantageous to the profession and its members Publishes a bimonthly magazine, *Occupational Therapy and Rehabilitation*, and an annual *Directory of Qualified Occupational Therapists.*

31. American Orthopsychiatric Association, Inc. 1790 Broadway, New York, N. Y. Address· Norvelle C. LaMar, M.D., secretary.

Unites and provides a common meeting ground for those engaged in the study and treatment of problems of human behavior, and fosters research and spreads information concerning scientific work in the field of human behavior, including all forms of abnormal behavior. Publishes the *American Journal of Orthopsychiatry* (four times a year) and the Research Monograph Series.

32. American Psychiatric Association. Room 708, 9 Rockefeller Plaza, New York, N. Y Address. Austin M Davies, executive assistant

Has a membership of 2700. Founded in 1844 to further the study of subjects pertaining to the nature, treatment, and prevention of mental disorders; to further the interests, maintenance, and advancement of standards of hospitals for mental disorders, of out-patient clinics, and of all other agencies concerned with the medical, social, and legal aspects of these disorders; to further psychiatric education and research. Publishes the *American Journal of Psychiatry,* bimonthly (six issues yearly).

33 American Public Health Association. 1790 Broadway, New York, N. Y. Address: Reginald M Atwater, M.D., executive secretary.

The professional society of public health workers of North America, with a membership of 7000. Works thru its ten sections and more than 100 committees. Thru its section on public health education, comprising nearly one-seventh of the total membership, it sponsors an institute on health education in connection with its annual convention, and publishes reports and papers on health education separately and in its official publication, the *American Journal of Public Health.* Recently published a study on *Community Organization for Health Education.*

34. American Public Welfare Association. 1313 East 60th Street, Chicago, Ill Address· Fred K. Hoehler, director.

Serves public welfare agencies and officers in the development of sound and adequate programs for persons in need of public assistance and other welfare services. Provides guidance in the areas of medical and hospital service for clients of public agencies. Operates thru the following means· consultation service, studies of organizational problems, national and regional conferences, maintenance of a loan library for members, field visits, committee activities. and publications. Publishes *Public Welfare News* (issued monthly).

35. American School Health Association. Address: A. O. DeWeese, M.D , executive secretary-treasurer, Kent State University, Kent, Ohio.

An association of physicians, dentists, nurses, and health directors engaged in school health work in the public schools, private schools, and universities of the United States and Canada. Publishes the *Journal of School Health,* a monthly magazine. Holds one national meeting during year and several regional and state meetings. Thru widespread committees which are constantly studying school health problems, consultation to members is offered.

36. American Social Hygiene Association. 1790 Broadway, New York, N. Y. Address: Walter Clarke, M.D., executive director.

Informs the public about the national program and needed community action; combats syphilis and gonorrhea as dangerous communicable diseases; fights prostitution as an organized business and improves other unwholesome conditions, particularly community conditions which lead to sex delinquency among young people; promotes, from childhood on, sound sex education and training for marriage and parenthood; and by all these means protects and improves the American family as the basic social institution Works thru the educational facilities of home, church, school, press, radio, stage, and motion pictures, and thru direct contact with the public by letter and personal interview. Association services include personnel for advice, consultation, and field work including state and community surveys, and distribution of books, pamphlets, exhibits, films, periodicals, and other materials. Important continuing projects are National Social Hygiene Day and special services to youth. Publishes *Journal of Social Hygiene,* monthly except July, August, and September, $3 a year; and *Social Hygiene News,* monthly.

37. American Society for the Control of Cancer, Inc. 350 Madison Avenue, New York, N. Y. Address: C. C. Little, managing director.

Collects and disseminates information on all aspects of the cancer problem. Chief purpose is to save lives thru education. Is authorized to cooperate with recognized medical agencies to help improve treatment facilities. The lay educational program is directed by the Women's Field Army which conducts an annual nationwide campaign to fight cancer; prepares and distributes free literature, motion pictures, radio programs, film strips, statistics, exhibits, newspaper releases; and maintains free information bureau. Retains a special representative in the Midwest to administer the educational program among high-school and college students. Special material is available for these groups. Publishes a monthly bulletin, articles on cancer for the lay public and physicians, $1 a year.

38. American Society for the Hard of Hearing. 1537 35th Street, N. W., Washington, D. C. Address: Betty C. Wright, executive director.

Serves as an information center on problems related to the hard of hearing and coordinates and directs the work of local societies for the hard of hearing.

Promotes hearing tests in schools that incipient cases of deafness may be discovered and treated. Advocates for both children and adults prompt medical attention, lip reading, and accepted hearing aids if needed Gives vocational advice. Publishes *Hearing News* monthly ($2 a year), and *Conference Proceedings* biennially ($1 each). Sells for nominal sum pamphlets dealing with problems of the hard of hearing. Price list sent on receipt of addressed and stamped envelope.

39. American Society of Heating and Ventilating Engineers. 51 Madison Avenue, New York, N. Y. Address· A. V. Hutchinson, secretary.

Sponsors research for the determination of physiological reactions of people to their atmospheric environment and has established comfort standards for occupied spaces. Membership includes consulting specialists on heating, ventilating, and air conditioning problems. Maintains local organizations in thirty principal cities of the United States and Canada and publishes periodic research reports, as well as engineering handbook devoted to design and application of heating, ventilating, and air conditioning systems and equipment.

40. American Youth Hostels, Inc. National Headquarters, Northfield, Mass. Address: Monroe W. Smith, executive director.

Improves physical and mental health of young persons who travel the youth hostel way by encouraging happy, healthful travel by foot, bike, horseback, canoe, skis, or snowshoes, over secondary roads and byways of the country. Youth hostels are located on an average of fifteen miles apart. A hostel, chaperoned by house-parents, consists of separate bunkrooms and washrooms for boys and girls, common recreation rooms, and kitchen facilities. The overnight fee is 25¢ (plus fuel charge of 5¢ in summer and 10¢ in winter). Publishes. quarterly *AYH Knapsack;* annual *AYH Handbook; Thrill of New Trails* folder; travel folder.

41. Association for Childhood Education. 1201 Sixteenth Street, N. W., Washington, D. C. Address: Mary E Leeper, executive secretary.

Cooperates with other national groups dealing with health; includes in almost every national convention a program study class or a general session on some phase of health education, for example, in 1941 had a class on "Mental Health of Children and Adults"; publishes articles in *Childhood Education* on health and health education; encourages local study groups to become acquainted with and participate in community health education programs; prepares annually a selective bibliography on health education which is used in answering inquiries received. Publishes *Childhood Education* (nine issues yearly).

42. Audio-Visual Research Foundation. Evanston, Ill. Address: Louis D. Goodfellow, executive director.

Primarily a research organization in the fields of hearing and vision and their defects. Operates a psycho-educational clinic, offering the following nonmedical services to all classes of physically handicapped persons: home instruction programs; guidance in learning fundamental activities; guidance in personality development and adjustment; vocational guidance; speech correction and training; re-education of defective hearing; and advice on the use of hearing aids

43. Child Welfare League of America, Inc 130 East 22d Street, New York, N. Y. Address: Howard W. Hopkirk, executive director.

Improves organized service for physically, mentally, and socially handicapped children in the United States and Canada, and especially the work by its member organizations, thru the following means. consultation service; studies of community programs or of separate organizations; national and regional conferences; teaching; interchange of service, especially between members; circulation of a loan library among members; maintenance of an exhibit of case records; publication of a bulletin, record forms, and other literature; and general information service pertaining to child welfare, particularly foster care and protective work. Publishes *Monthly Bulletin* (ten issues yearly).

44. Committee on Research in Medical Economics, Inc. 1790 Broadway, New York, N. Y. Address: Michael M. Davis, chairman.

Pursues and stimulates studies concerning the social and economic aspects of medicine; publishes a quarterly journal *Medical Care* (annual subscription $3) covering this field; supplies advisory service concerning research and current practical problems in this field; will supply suggestions and reading lists for teachers' or students' use. Some pamphlets available for free distribution, other material for stated charges.

45 Consumers' Research, Inc. Washington, N. J. Address: F. J. Schlink, technical director.

A nonprofit, noncommercial, research and educational organization which studies, tests, and reports on goods and services as to their selection, purchase, and use by consumers. Provides the following types of service: (a) nine nonconfidential monthly *Bulletins,* and an *Annual Cumulative Bulletin* (confidential, available only to subscribers who sign an application blank), $3 a year; and (b) *Consumers' Research Bulletin* (school and library service), consisting of nine nonconfidential issues, $2 a year, October thru June. The latter service open to associations, corporations, libraries, schools, colleges, teachers colleges, and adult study groups interested in consumer problems, buymanship, and consumer education. The *Bulletins* present new information on questions of food, health and hygiene, textiles and clothing, household appliances and equipment. Other material available: special bulletins, bibliographies, reviews of books on consumer problems, reprints and articles bearing on consumer goods and services.

46. Consumers Union of United States, Inc. 17 Union Square, New York, N. Y. Address: Lydia Altschuler, educational director.

A nonprofit organization whose main activity is testing and rating consumer goods. Findings are issued in three publications: *Buying Guide* (annually), Consumers Union *Reports* (monthly), and *Bread & Butter* (weekly). The *Buying Guide* and *Reports* emphasize mainly the test results; products are rated as "best buys," "also acceptable," or "not acceptable." Authoritative articles on health, checked by Consumers Union's advisory board of medical specialists, appear monthly in the *Reports.* Emphasis in *Bread & Butter* is mainly on economic trends affecting the prices and quality of consumer goods. The *Reports* and *Bread &Butter,* however, both include buying advice and general articles. The *Reports* are used extensively in schools. Issues free Consumer Class Plans to aid teachers. Inquiries from teachers are invited.

47. Elizabeth McCormick Memorial Fund. 848 North Dearborn Street, Chicago, Ill. Address: Mary E. Murphy, director.

Organized to improve the condition of child life in the United States. Assists schools and child care institutions in carrying forward health education programs thru consultation services, surveys, experimental studies, and demonstrations. Services concern physical and mental growth, improvement in dietary practices and general health, guidance of school children, and organized group work with parents.

48. Institute for Consumer Education. Stephens College, Columbia, Mo. Address: John M. Cassels, director.

Considers phases of health education which are specifically related to consumer education; prepares and distributes study outlines, bibliographies, and other materials dealing with certain health problems to schools, colleges, and adult groups. Publishes *Consumer Education,* a newsletter (nine issues yearly—subscription, 25¢).

49. Iowa Child Welfare Research Station. University of Iowa, Iowa City, Iowa. Address: George D. Stoddard, director.

Conducts extensive investigations in development at infant, child, and youth levels including mental, emotional, social, and physical growth; preschool education; mental hygiene; and parent education. Also supervises university preschools and parent education programs thruout the state. Investigations include relation of physical growth measures to health and disease, effect of factors on mental health, and effectiveness of educational programs. Publishes an extensive series of research monographs and popular pamphlets for general reading.

50. John Hancock Mutual Life Insurance Company. 197 Clarendon Street, Boston, Mass. Address: Life Conservation Service.

Publishes and distributes free twenty-six booklets on adult and child hygiene, disease prevention, care of the sick, and first aid. These publications are prepared primarily for adult policyholders but are available in limited quantities for the use of social and educational agencies. The booklets are written for adults and are not suitable for distribution to young school children but may prove useful as teaching material. Sample sets of the booklets will be sent upon request.

51. Laymen's League against Epilepsy. Harvard Medical School, 25 Shattuck Street, Boston, Mass. Address: Mrs. Bond Fleming, secretary.

Affiliated in activity with the American branch of the International League against Epilepsy, composed of physicians. Objects of Laymen's League—education of the public and support of medical research. News bulletins to members. Sponsor of 250-page educational book, *Science and Seizures,* Harper and Brothers, $2. Collaborates in publication of *Epilepsia,* an annual digest of world literature on epilepsy. Consultative service with school authorities. Annual membership dues—ordinary $1, sustaining $5. All members of League receive a copy of *Science and Seizures* and sustaining members receive *Epilepsia.*

52. Metropolitan Life Insurance Company, School Health Bureau, Welfare Division 1 Madison Avenue, New York, N. Y. Address: Donald B. Armstrong, M.D., third vicepresident.

The purpose of the educational services offered is the enrichment and prolongation of life thru school health education. An advisory group of educational leaders from various sections of the United States and Canada guides the Bureau in determining what gaps exist in the school health program and how a life insurance company may appropriately assist in filling these gaps. Special consideration is given to health education problems thru correspondence and consultation. Educational exhibits are displayed at national meetings; research is conducted; demonstrations are carried on; and special school health literature and visual aids are distributed to teachers and administrators upon request. All school health services are available without charge.

53. National Association of Biology Teachers. Address: P. K. Houdek, secretary-treasurer, Township High School, Robinson, Ill.

An organization of and for biology teachers cooperating with twenty affiliated locals in various parts of the country. Promotes the teaching of health as a part of biology by means of articles in its journal and programs of its national, regional, and local meetings. Sponsors a national committee on health and hygiene headed by Brother H. Charles, Saint Mary's College, Winona, Minnesota. Sponsors no formal consultation service. Officers and committee offer assistance. Publishes the *American Biology Teacher* (eight issues, October thru May).

54. National Board of Fire Underwriters. 85 John Street, New York, N Y. Address: W. E. Mallalieu, general manager.

Publishes standards, recommended safeguards, and brochures on various phases of fire prevention and fire protection; self-inspection forms and related material for use of school administrators in minimizing fire hazards in school properties; manuals and textbooks suitable for schoolroom use on fire safety. Material free in reasonable quantities.

55. National Committee for Mental Hygiene, Inc. 1790 Broadway, New York, N. Y. Address. George S. Stevenson, M D., medical director.

Assists communities in the development of facilities for mentally handicapped children by advice in organization, assistance in securing personnel, training of personnel, sponsoring research, surveying existing services, conducting experiments in teacher selection, and the teaching of mental hygiene. Publishes *Understanding the Child,* a mental hygiene periodical for teachers; the quarterly, *Mental Hygiene;* and numerous pamphlets; prepares bibliographies.

56. National Conference for Cooperation in School Health Education. 1201 Sixteenth Street, N. W., Washington, D. C. Address. N. P. Neilson, secretary.

A clearing-house type of conference, the membership of which is made up of over forty national and international organizations and agencies in health and education, both governmental and voluntary. The organization does not distribute health education material but furnishes a medium of cooperation thru which its constituent agencies may work together in the production of such material.

57. National Conference on Family Relations. 1126 East 59th Street, Chicago, Ill. Address: Mary K. White, executive director.

Seeks to advance the cultural values that are now principally secured thru family relations for the advantage of the individual and the strength of the nation, thru (a) national, regional, and state conferences in which are presented important research findings, points of view, experience, and proposals for family welfare; and (b) work of continuing national committees. The Committee on Education for Marriage and the Family on the High School Level is concerned with the development of courses on family living in which family health is included as one important phase. Publishes *Marriage and Family Living* (four issues yearly), included in membership.

58. National Congress of Colored Parents and Teachers. State Teachers College, Bowie, Md. Address: Leonidas S. James, executive secretary.

Fosters an annual summer roundup of preschool children; donates funds for the correction of physical defects discovered in preschool and school children; donates funds for the purchase of medicine, medical equipment, and both dental and medical service; helps in the provision, preparation, and serving of hot lunches for school children in small urban and rural communities. Supports, plans, and participates in an Annual Negro Health Week. Distributes outlines on health and safety education for children, parents, and other adults; also other literature. Publishes a quarterly bulletin entitled *Our National Family*.

59. National Congress of Parents and Teachers. 600 South Michigan Boulevard, Chicago, Ill.

Works to promote the welfare of children and youth in home, school, church, and community; to raise the standards of home life; to secure adequate laws for the care and protection of children and youth; to bring into closer relation the home and the school that parents and teachers may cooperate intelligently in the training of the child; and to develop between educators and the general public such united efforts as will secure for every child the highest advantages in physical, mental, social, and spiritual education. Since 1925 has carried on the summer roundup of the children as a major health activity in local units to arouse the interest of parents in improving the health of children entering school for the first time, and to bring about continuous medical and dental supervision of children of all ages, especially those apparently healthy. Cooperates with the school health program and with community medical, dental, and nursing professions and health agencies Thru twenty-one national committees, the Congress promotes all phases of child welfare. Publishes *National Parent-Teacher Magazine* and *National Congress Bulletin* (monthly September thru June), and *Proceedings* (annually).

60. National Dental Hygiene Association, Inc. 934 Shoreham Building, Washington, D. C. Address: Randolph G Bishop, executive secretary.

Sponsored by the Martha M. Hall Foundation in Memory of William Henry Hall; dedicated to the advancement of the dental health of the American people, with major emphasis upon school and preschool children. Promotes the formation of community dental health committees in seeking to bring together in every community the school officials, official and unofficial health and welfare agencies, and lay organizations for the development of more adequate dental programs. Provides factual and promotional dental health education literature and posters. Serves as a source of general information concerning dental health programs. Seeks the support of lay organizations and individuals in the advancement of dentistry for children. Free publications: *A National Program for the Advancement of Dental Health, Community Committees for Dental Health,* and *The Army's Toothache—An Old Story.*

61. National Foundation for Infantile Paralysis, Inc. 120 Broadway, New York, N. Y.

Publishes pamphlets and books for the professional and lay public, relative to infantile paralysis. Thru its 1300 permanent chapters in more than 1700 counties, renders direct aid to indigent infantile paralysis patients regardless of age, within the territory assigned to the chapter. The chapters do this by supplying orthopedic equipment and helping pay hospital bills and medical and nursing costs. During epidemics, chapters render assistance not only to those afflicted but to the medical profession and the public health officers in charge.

62. National Organization for Public Health Nursing. 1790 Broadway, New York, N Y. Address: Dorothy Deming, general director.

A membership organization made up of public health nurses, laymen, and agencies concerned with public nursing. Defines functions and qualifications of the public health nurse in various types of public health nursing positions, including school nursing, industrial nursing, orthopedic nursing, and generalized public health nursing. Thru field visits, studies of community services, group conferences, correspondence, and publication of its magazine *Public Health Nursing,* it helps the individual nurse, lay person, or agency to keep informed on and to handle current problems in public health nursing. Publishes *Public Health Nursing* (twelve issues yearly—$2 a year to members and $3 a year to nonmembers).

63. National Physical Education Service. 315 Fourth Avenue, New York, N. Y. (Maintained by the National Recreation Association) Address: James E. Rogers, director.

Promotes statewide programs of physical education in the public schools and serves state departments of education which already have established physical education curriculums. Among the services available are field service and correspondence service. Publishes *News Letter* (ten issues yearly).

64. National Recreation Association. 315 Fourth Avenue, New York, N. Y. Address· Howard S. Braucher, secretary

Contributes to the physical and mental health of children and adults by helping to expand the opportunities for play and recreation in the United States. The services of the Association are available, within the limits of the Association's resources, to any public or private organization or any individual with problems in its field. Among services which are available are the following: correspondence and consultation service, publications service, play in institutions service, field service, national physical education service, special service for women and girls, service to colored communities, national recreation congress. Publishes *Recreation* (monthly), *Recreation Bulletin Service* (twice monthly except August), the *Recreation Year Book* (annually), miscellaneous books, booklets, pamphlets.

65. National Society for the Prevention of Blindness. 1790 Broadway, New York, N. Y. Address: Mrs. Eleanor Brown Merrill, executive director.

Ascertains causes of blindness or impaired vision; advocates measures leading to the elimination of such causes; brings the knowledge of eye hygiene in popular form to children and adults; and acts as a clearing-house and stimulating agent for others engaged directly or indirectly in the prevention of blindness and conservation of vision. Among the services carried on by the Society are: combating prenatal syphilis; preventing eye infections of newborn babies and eye accidents in child play, promoting eye examination for preschool children and eye health in the school program, promoting the integration of eye health programs in teacher education; establishing sight-saving classes; training teachers, nurses, and medical social eye workers; developing medical social service in eye clinics; and eliminating eye hazards in industry. Publishes *Sight-Saving Review* (quarterly), *News Letter, Sight-Saving Class Exchange* (four issues yearly), *Medical Social Workers in Eye Services News* (published occasionally), and issues a number of publications dealing with prevention of blindness and conservation of vision.

66. National Tuberculosis Association. 1790 Broadway, New York, N. Y. Address: Louise Strachan, director, child health education.

Maintains a Child Health Education Service designed to stimulate interest in schools and educational systems in health-habit training and better health work for children, laying particular emphasis on the health training of teachers. This includes: providing school health consultant service; publishing a bibliography of free and inexpensive health education material for teachers for the American Association for Health, Physical Education, and Recreation, a department of the National Education Association; participating in the summer roundup of children sponsored by the National Congress of Parents and Teachers; cooperating with the American Student Health Association in the promotion of college hygiene; furthering a program of health education in Negro schools and colleges, including the organization of the National Student Health Association. For a general statement regarding the activities of the National Tuberculosis Association refer to the 1941 yearbook of the American Association of School Administrators, *Education for Family Life,* page 193, item No. 61.

67. National Woman's Christian Temperance Union 1730 Chicago Avenue, Evanston, Ill. Address: Bertha Rachel Palmer, director of alcohol education

Provides definite information thru printed material and films, both sound and silent, on the relation of alcohol in drinks and mixtures to safety and efficiency (because of functional changes within fifteen minutes after drinking), and to health (because of tissue changes resulting from moderate drinking over a period of seven to ten years). In general, the material is prepared for use of classroom teachers at the different educational levels from primary to college; a limited amount is suitable to be put into the hands of class members. Publishes *The Union Signal,* a journal of social welfare—scientific articles by authorities in many welfare fields (fifty issues yearly).

68. New York University, Center for Safety Education. 20 Washington Square North, New York, N. Y. Address: Herbert J. Stack, director.

Aids in the development and improvement of school health programs embracing safety education thru the following means: annual award of approximately ten fellowships and sixty tuition scholarships to teachers and administrators preparing for leadership in safety education; assistance in the preparation of courses of study and curriculum materials; preparation and distribution of tests, lesson outlines, bibliographies, manuals, audio-visual aids, radio scripts, and other materials which treat of various phases of safety education related to health, physical education, and recreation; consultant and field services; lecture-demonstrations and exhibits; and research investigations in areas of safety education related to problems of health.

69. Progressive Education Association. 221 West 57th Street, New York, N Y. Address: Frederick L. Redefer, director.

Conducts research, conferences, and publishes *Progressive Education* (eight times yearly), in all of which the development of the whole child is stressed, with physical development and health emphasized thru special studies, special issues of the magazine, special section meetings at conferences.

70. Society for Research in Child Development. National Research Council, 2101 Constitution Avenue, Washington, D C. Address: Carroll E. Palmer, secretary-treasurer.

An organization of scientific investigators of various phases of child development, health, and welfare. About 550 members from all parts of the United States and Canada. Promotes original research, also digests of research findings which may be of service to those concerned with the development of children and adolescents. Publishes· *Child Development* (quarterly, $4 a year—free to members); *Child Development Abstracts and Bibliography* (bimonthly, $5 a year—free to members); *Monographs of the Society for Research in Child Development* (yearly volume issued irregularly, $4 a year —free to members). Dues to the Society, $5 a year.

71 Society of State Directors of Health and Physical Education. Address: Bernice Moss, president, State Department of Public Instruction, Salt Lake City, Utah.

The members of the Society are always ready to render service to school health programs, including guidance and direction thru courses of study, printed and mimeographed bulletins, yearbooks, and newsletters.

72. University of Minnesota, Institute of Child Welfare. Minneapolis, Minn. Address: John E. Anderson, director.

Conducts research on the development of the child from birth to maturity, including the physical, psychological, and social aspects of development; maintains an instructional program within the University preparing students at the undergraduate and graduate level for work in the field of child development and family relations; conducts a parent education program, disseminating information on the development and guidance of children to parents in the state of Minnesota; publishes many scientific articles and monographs in scientific journals and issues bulletins and practical publications from time to time.

Federal Governmental Agencies

73. Federal Security Agency. Washington, D. C. Address: Honorable Paul V. McNutt, director, Office of Defense Health and Welfare Services.

Utilizes the services of various federal agencies administering health, welfare, and related activities as far as these activities are involved in the objectives of the national defense program. The office of the director carries out its functions thru (a) direct operation and (b) committee organization An Interdepartmental Advisory Council composed of the heads of all federal organizations whose activities pertain to health, welfare, and related activities advises the director and determines policies. In addition, advisory committees on health and medical care, family security, nutrition, education, and recreation consider problems in these respective fields. Twelve regional advisory committees, each with a regional defense coordinator, perform for each region the same functions as are carried out by the Interdepartmental Advisory Council. Health and medical problems dealt with include: the need for medical service, scientific knowledge of medical problems related to defense, civilian health, population expansion, industrial hygiene, essential medical materials, nutrition education, adequate food supplies, and recreation for military service and civilian population.

74. Federal Security Agency, U. S. Office of Education. Washington, D. C Address· John W. Studebaker, commissioner.

Conducts research and furnishes information on all phases of health work in schools and colleges; issues many special publications in this field; publishes a monthly journal, *School Life,* which contains articles on health and physical education.

75. Federal Security Agency, U. S. Public Health Service. Washington, D. C. Address: The Surgeon General.

Produces and distributes free or at low cost educational materials on numerous individual and public health problems, including printed matter, posters, exhibits, radio transcriptions, and motion pictures; studies public health education methods and programs in cooperation with state and local health departments and other agencies; provides information on sources of health education materials.

76. U. S. Department of Agriculture, Bureau of Home Economics. Washington, D. C. Address· Ruth Van Deman, chief, Information Division.

Works for better health among school children primarily thru its research and resulting information on foods and nutrition, available to the public by bulletin, poster, film strip, radio, press, as well as correspondence. This includes information on why the body needs good food, nutritive values of various foods, and how to conserve these food values in the preparation of appetizing meals. While many of the Bureau's publications are designed for home economics teachers and homemakers, the new leaflet, *Eat the Right Food to Help Keep You Fit,* is in terms simple enough for use directly with the school child. Cooperating with the Surplus Marketing Administration, the Bureau has published *School Lunches Using Farm Surpluses,* giving menus and recipes in quantity for groups of ten, twenty-five, and fifty school children. Other work of the Bureau concerned with child health includes the study of healthful and safe clothes for children, and the study of family economics, especially that of the cost of medical care. Many of the Bureau's publications are free; for some there is a nominal charge.

77. U. S. Department of Agriculture, Extension Service. Washington, D. C. Address: M. L. Wilson, director.

The cooperative extension work in which the federal Department of Agriculture, the state land-grant colleges, and the county governments participate cooperatively, is an educational system responsible for bringing to farm families the newest and best methods of farming and homemaking. The common goal is that of better living for the farm family. Its program includes educational work in nutrition requirements for good health, home sanitation, and disease and accident prevention. Its work with young people, ten years of age and over, is carried on thru the 4-H Clubs. Extension agents are located in every county of agricultural importance and cooperate with all agencies conducting programs relating to improvement in rural matters. Publishes *Extension Service Review* (monthly).

78. U. S. Department of Labor, Children's Bureau. Washington, D. C. Address: Katharine F. Lenroot, chief

Issues bulletins, folders, and posters on maternal care and on child care and training written primarily for parents, suitable for use in high schools and colleges. Lends films and exhibit material on child care and training. Conducts research and gives consultation service on child care and training based on research. Administers grants to the states for maternal and child health services and services for crippled children under the Social Security Act, and advises state health officials on use of whatever funds are budgeted for health education programs for professional health workers and parents and, in cooperation with school agencies, for teachers and school children. Issues publications on state and community maternal and child health services and services for crippled children. Issues, for those actively engaged in the care of children, a monthly bulletin, *The Child,* including articles on maternal and child health. List of publications on request.

79. Work Projects Administration. 1734 New York Avenue, N. W., Washington, D. C. Address: Florence Kerr, assistant commissioner.

Operates school lunch projects in forty-seven states, the District of Columbia, New York City, and the Virgin Islands. About two million children were fed daily during the 1940-41 school year. In thousands of schools, the pupils have had their teeth, ears, and eyes examined by professional and nonprofessional staffs provided by the Work Projects Administration to the local communities. In some cases, school clinics assisted by WPA aides have furnished the necessary treatments to children whose parents cannot afford to pay for medical or dental care.

SPEECH CLINICS AND INSTITUTIONS OFFERING SPEECH CORRECTION TRAINING

The following list of speech clinics and speech correctionist training institutions is a tentative one prepared by the American Speech Correction Association (reproduced here thru the courtesy of Dr. Herbert Koepp-Baker). The institutions listed here conform to certain standards of professional training and practice established by that Association.

Universities and Colleges

*Brigham Young University, Provo, Utah
Brooklyn College, Brooklyn, New York
*Emerson College, Boston, Massachusetts
Fort Hays Kansas State College, Hays, Kansas
*Indiana University, Bloomington, Indiana
*Louisiana State University, University, Louisiana
Municipal University of Wichita, Wichita, Kansas
*Northwestern University, Evanston, Illinois
*Ohio State University, Columbus, Ohio
*Pennsylvania State College, State College, Pennsylvania
*Purdue University, Lafayette, Indiana
Queens College, Flushing, New York
*State University of Iowa, Iowa City, Iowa
*Syracuse University, Syracuse, New York
*University of Denver, Denver, Colorado
*University of Illinois, Urbana, Illinois
*University of Michigan, Ann Arbor, Michigan
*University of Minnesota, Minneapolis, Minnesota
University of Pennsylvania, Philadelphia, Pennsylvania
*University of Southern California, Los Angeles, California
*University of Washington, Seattle, Washington
*University of Wisconsin, Madison, Wisconsin
*Wayne University, Detroit, Michigan

Hospitals and Medical Colleges

Children's Memorial Hospital, Chicago, Illinois
Cornell University Medical College, New York, New York
Harlem Hospital, New York, New York
Mt. Sinai Hospital, New York, New York
Rush Medical College, University of Chicago, Chicago, Illinois

Teachers Colleges and Schools of Education

*Columbia University, Teachers College, New York, New York
*Indiana State Teachers College, Terre Haute, Indiana
*Northern Illinois State Teachers College, De Kalb, Illinois

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* Teacher education in clinical speech is emphasized

- *State Normal School, Fredonia, New York
- *State Teachers College, California, Pennsylvania
- *Western Washington College of Education, Bellingham, Washington
- *Western State Teachers College, Kalamazoo, Michigan

Special Schools

- *Central Institute for the Deaf, St. Louis, Missouri
- Hill-Young School of Speech, Ellensdale Place, Los Angeles, California
- Junior League School for Speech Correction, Peachtree Street, Atlanta, Georgia

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* Teacher education in clinical speech is emphasized

OFFICIAL RECORDS

AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS

A Department of the National Education Association
of the United States

Officers 1941-42

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HOMER W. ANDERSON, Superintendent of Schools, St. Louis, Mo.

STANLEY H. ROLFE, Superintendent of Schools, Newark, N. J.

The President, First and Second Vicepresidents, ex officio

ANNUAL REPORT OF THE EXECUTIVE SECRETARY

To the President, Executive Committee, and Members:

IN ACCORDANCE with the provisions of the constitution adopted at the New Orleans convention in 1937, the annual report of the activities of the American Association of School Administrators is presented herewith. It covers the period from January 1, 1941, to December 31, 1941.

The Atlantic City Convention

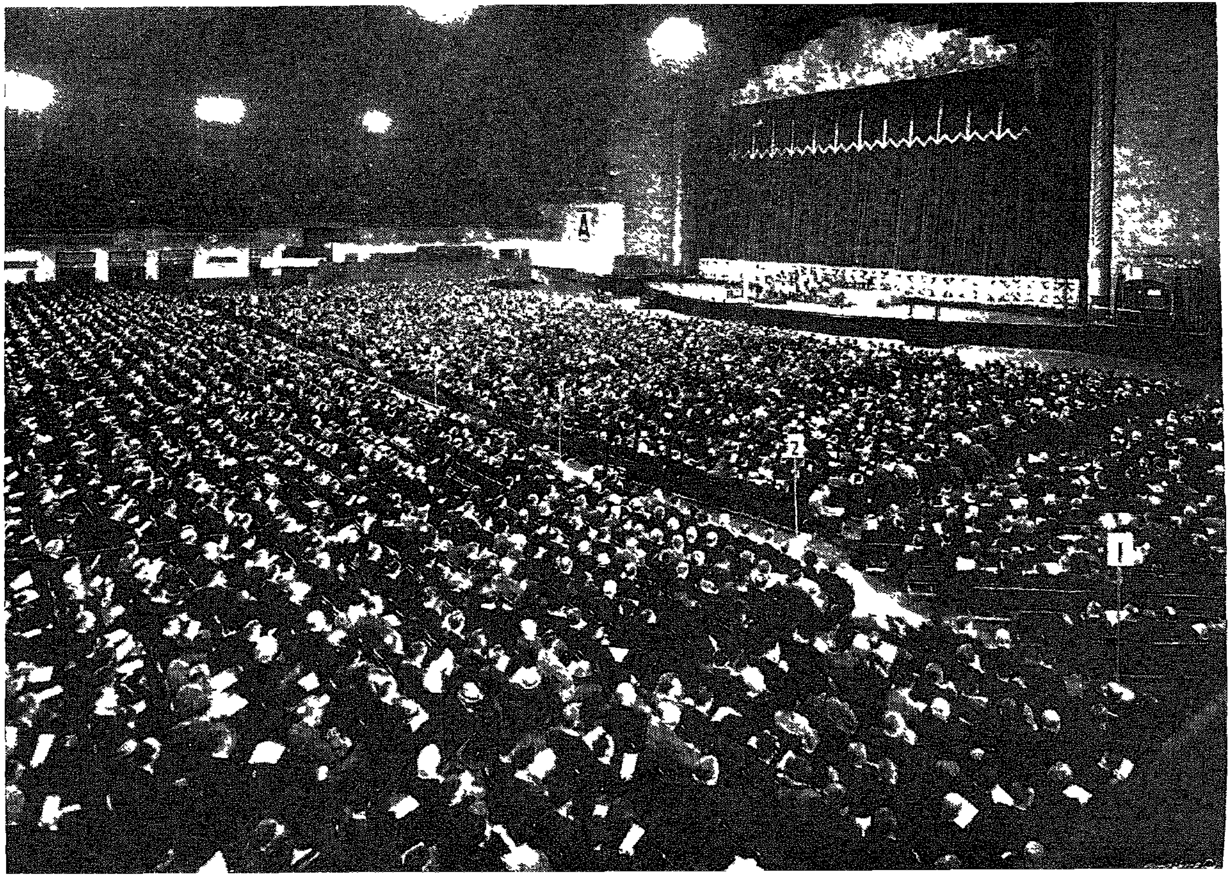
Immediately after he assumed the office of president of the American Association of School Administrators in March 1940, Superintendent Carroll R. Reed began making his convention plans. With remarkable foresight he turned to the Preamble to the Constitution of the United States for a convention theme. Three clauses were selected for special emphasis:

> To Provide for the Common Defense
> To Promote the General Welfare
> To Secure the Blessings of Liberty.

Atlantic City has ideal convention facilities. By actual count, 11,770 persons attended the 1941 convention. Newspapers reported that never before in the winter season had the hotels been called upon to entertain so many guests. Harassed hotel clerks in the Boardwalk hotels turned away hundreds of applicants for rooms, advising them to seek accommodations in Avenue hotels or in private residences.

The exhibits were conveniently located on the first floor of the Auditorium. There were 282 participating firms and organizations. The spacious arena, unobstructed by posts, provided an ideal setting for the attractive and instructive displays. An interested throng of Association members packed the exhibit area from the time it opened on Saturday morning, February 22, until it closed on Thursday afternoon, February 27.

In serious fashion the convention went about its work. "Citizens of Tomorrow" was the topic chosen by a great churchman, The Reverend Ralph W. Sockman of New York City, for his address at the opening vesper service on Sunday afternoon. He urged the need



View of the audience in the arena looking toward the stage, Tuesday evening, February 25 for the schools to protect youth from the pessimism of current philosophy and theology and to help them to feel that there is a future worth working for.

In the keynote addresses on Monday morning, Governor Harold E. Stassen of Minnesota, United States Commissioner of Education John W. Studebaker, and former Congressman T. V. Smith of the University of Chicago discussed the contributions which education can and should make in providing for the common defense. Among other things, American education must promptly contribute to the vocational effectiveness of the present and future workers of the nation; it must build a morale capable of facing unflinchingly the difficulties ahead; it must give youth courage, hope, and understanding to cope with the great crises which threaten the future of free men everywhere.

On Monday evening, President Isaiah Bowman of Johns Hopkins University pointed out that the only way to meet the costs involved in the impending conflict is by lowering the standard of living. This cost is likely to be chiseled out of schools, museums, art galleries, quality and amount of food, clothing, house furnishings, soil preservation, care of the blind and insane, hospitalization, road repair, and hours of leisure.

As a part of the discussion of the topic, "To Promote the General Welfare," Professor John K. Norton of Teachers College, Columbia University, stressed the relationship between education and economic well-being; President Philip Murray of the CIO spoke of labor's part in the solution of America's problems; and Superintendent Willis A. Sutton of Atlanta, Georgia, pointed out that more education means more business. Mr. Sutton said that increasing an individual's appreciation of and desire for better things helps to improve business. Education is the basis of real, genuine production of wealth. Where better education prevails, not only better foods and clothing are called for but also more newspapers, telephones, household appliances, musical and art goods, and luxuries of all types are in demand. Investment in school taxes leads to more business and more profitable business.

The Associated Exhibitors were hosts to the American Association of School Administrators and the National Education Association on Tuesday evening in the arena of the Auditorium. Delightful entertainment was furnished by Gladys Swarthout, Metropolitan Opera star; the Quiz Kids of radio fame; and the National Broadcasting Company Orchestra, directed by Harry Meyer. The Exhibitors presented the American Education Award for 1941 to Frank P. Graves who was commissioner of education for the state of New York from 1921 to 1940.

"Education for Family Life" was the theme of the Wednesday morning program. Members of the commission which prepared the 1941 yearbook on this topic were platform guests. Dean E. W. Jacobsen of the School of Education at the University of Pittsburgh, chairman of the Yearbook Commission, presided. By means of song and beautifully spoken words, the finer values of home and family life were portrayed. The hearts of the audience were deeply stirred by this part of the program which was presented by the Heinz Memorial Chapel Choir and the Drama Department of the University of Pittsburgh. Next, President Aurelia Henry Reinhardt of Mills College, California, spoke on "The American Home and American Education." The program concluded with a preview of an actual broadcast entitled "And by the People," which was later presented over the Red Network of the National Broadcasting Company. The script of this program was inspired by the 1941 yearbook, *Education for Family Life*.

At an inspiring session, the convention closed with a discussion of international relations. Colonel George Drew, Leader of His Majesty's Loyal Opposition for the Province of Ontario, Canada, presented Canada's view of Pan-Americanism. Dr. Hu Shih, Ambassador from China to the United States, called for a clear realization that it is the international situation which is threatening the common defense, the general welfare, and the blessings of liberty. With the radio we have in our hands an instrument of tremendous power for the furtherance of friendship and goodwill toward our neighbors. Thru the courtesy of the Columbia Broadcasting System, the audience saw and heard a presentation from the stage of a regular program in the series, "School of the Air of the Americas." "The Dark Star of Itza," a story of the Mayans, was presented in costume and was broadcast to twenty-two nations of the Western Hemisphere.

Current educational problems were vigorously argued at the discussion group meetings which were held on the afternoons of Monday, Tuesday, and Wednesday of convention week. In all, over thirty of these groups met and considered problems such as: Military

Training and the Schools, Opportunities for the Rural Child, Developing an Effective Health Program in the Schools, Adequate Financial Support for the Schools, Meeting the Problems of Modern Youth, Selection of Textbooks, Religious Instruction, Our Relations with South American Countries, Conservation of Our Natural Resources, Occupational Adjustment, Physically Handicapped Children, and Selection of Teaching Personnel.

Among those not members of the profession who had places on the convention programs were: United States Congressman Joe Starnes of Alabama; Major George Fielding Eliot, well-known commentator on military affairs; Everett R. Clinchy, president of the National Conference of Christians and Jews; Gerhart Seger, political refugee from Germany; Ralph Hetzel, Jr., director of the Unemployment Division, CIO; Aubrey Williams, administrator of the National Youth Administration; Martin F. Carpenter, chief of the U. S. Employment Service Division, Social Security Board; Joseph T. Meade, vicechairman of the Committee on Educational Cooperation, National Association of Manufacturers; Carl P. Russell, supervisor of research, National Park Service; and James Marshall, president of the New York City Board of Education.

The Executive Committee

Article IV of the constitution provides that the Executive Committee shall consist of seven members. The president and first and second vicepresidents are members ex officio and are elected annually. Four members, chosen by election, hold office for terms of four years.

Four meetings of the Executive Committee were held during 1941, the first being at the Dennis Hotel on the opening day of the Atlantic City convention—Saturday, February 22. Members present were: Carroll R. Reed, Minneapolis, Minnesota, president; Ben G. Graham, Pittsburgh, Pennsylvania, first vicepresident; Hobart M. Corning, Omaha, Nebraska, second vicepresident; Jesse H. Mason, Canton, Ohio; J. W. Ramsey, Fort Smith, Arkansas; William J. Hamilton, Oak Park, Illinois; and Homer W. Anderson, St. Louis, Missouri. Others present were Executive Secretary Sherwood D. Shankland and Assistant Superintendent Henry H. Hill of St. Louis, Missouri, chairman of the Convention Summarization Committee.

Chairman Hill reported that good progress already had been made in the preparation of the Atlantic City convention *Summary*. As much of the copy as could be prepared in advance had been set in type and approved for printing. Mr. Hill stated that a luncheon meeting of the Summarization Committee would be held on Sunday, February 23, to make final plans for the reporting of the general sessions and afternoon discussion group meetings. He stated that the *Summary* would be available on Thursday afternoon, February 27.

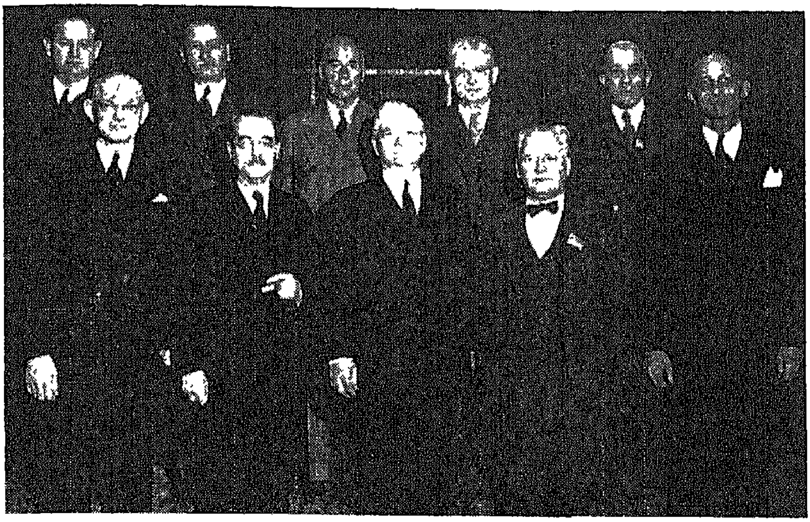
President Reed announced the appointment of Superintendent DeWitt S. Morgan of Indianapolis, Indiana, as chairman of the 1943 Yearbook Commission which is to deal with the problems of youth between the ages of sixteen and twenty-four.

A discussion was held of proposals to send to South America a group of school administrators to participate in a study of cultural relationships in the Western Hemisphere. It was stated that plans already were under way to bring a similar group of educators from South American countries to the United States. Later developments in connection with World War II necessitated the abandonment of these plans.

Superintendent Corning called attention to the fact that he had been delegated to represent the American Association of School Administrators in a radio debate on the selection of textbooks to be used in the public schools. In response to Mr. Corning's request, the members of the Executive Committee stated their opinions and personal experiences in connection with recent controversies about certain textbooks.

The Committee then recessed to Haddon Hall for a Smorgasbord given by the Columbia Broadcasting System. Following the Smorgasbord, the Committee attended the broadcast of the People's Platform on the topic, "Are Our Textbooks Subversive?" Mr. Corning participated in the broadcast which was heard on the coast-to-coast network of the Columbia Broadcasting System.

The new and old Executive Committees met in joint session at the Dennis Hotel at the close of the convention on Thursday afternoon, February 27. Members and officers present were: Carroll R. Reed, Minneapolis, Minnesota, president; W. Howard Pillsbury, Schenectady, New York, president-elect; Ben G. Graham, Pittsburgh, Pennsylvania, first vicepresident; Hobart M. Corning, Omaha, Nebraska, second vicepresident; Jesse H. Mason, Canton, Ohio; J. W. Ramsey,



Officers and Executive Committee of the American Association of School Administrators. Front row, left to right: J. W. Ramsey, Ben G. Graham, Carroll R. Reed, W. Howard Pillsbury, Hobart M. Corning. Back row, left to right: Jesse H. Mason, Homer W. Anderson, Stanley H. Rolfe, W. J. Hamilton, Sherwood D. Shankland

Fort Smith, Arkansas; William J. Hamilton, Oak Park, Illinois; Homer W. Anderson, St. Louis, Missouri; Stanley H. Rolfe, Newark, New Jersey, member-elect of the Executive Committee; Sherwood D. Shankland, executive secretary; and H. A. Allan, business manager of the National Education Association.

The executive secretary reported that the annual elections had been held according to the constitution and bylaws and that the tellers had certified to the election of the following officers, to take office March 15, 1941: W. Howard Pillsbury, superintendent of schools, Schenectady, New York, president; Worth McClure, superintendent of schools, Seattle, Washington, second vicepresident; Stanley H. Rolfe, superintendent of schools, Newark, New Jersey, member of the Executive Committee for four years.

Oral invitations for the 1942 convention were presented as follows: *Cleveland, Ohio*—by S. A. Weissenburger, executive vicepresident of the Cleveland Convention and Visitors' Bureau, Inc.; and by Joseph E. Burns, sales manager for the Hollenden Hotel. *San Francisco, California*—by Superintendent Joseph P. Nourse; by Frank M.

Wright, president of the Association of California Public School Superintendents; and by Walter G. Swanson, vicepresident and general manager of the San Francisco Convention and Tourist Bureau.

Speaking in behalf of Atlantic City, A. H. Skean, manager of the Convention Bureau; A. C. Poffenberger, president of the board of education; and Superintendent A. S. Chenoweth expressed thanks to the Executive Committee for having held the convention in Atlantic City. President Reed responded with words of appreciation for the fine way in which the details of the convention had been handled locally.

On motion of Mr. Mason, seconded by Mr. Graham, President-Elect Pillsbury was given power to act in the matter of securing information on the facilities of the cities extending invitations for the 1942 convention.

On motion of Mr. Ramsey, President Reed and Secretary Shankland were authorized to pay all bills of the Association up to the close of the Atlantic City convention, issuing checks against the special account of the Association in the usual manner.

The annual meeting of the Executive Committee was held in the Benjamin Franklin Hotel, Philadelphia, Pennsylvania, on May 2. Members present were: W. Howard Pillsbury, Schenectady, New York, president; Carroll R. Reed, Minneapolis, Minnesota, first vicepresident; Worth McClure, Seattle, Washington, second vicepresident; J. W. Ramsey, Fort Smith, Arkansas; William J. Hamilton, Oak Park, Illinois; Homer W. Anderson, St. Louis, Missouri; and Stanley H. Rolfe, Newark, New Jersey. Others present were H. A. Allan, business manager of the National Education Association; Gladys E. Harlow, chief clerk of the American Association of School Administrators; and Sherwood D. Shankland, executive secretary.

The facilities of the two cities inviting the 1942 convention of the Association—Cleveland and San Francisco—were given careful consideration. President Pillsbury outlined in some detail his recent inspection trip to San Francisco in company with Superintendent Reed and Secretary Shankland. He expressed the opinion that the city had ample physical facilities for handling the convention and that a fine spirit of cooperation prevailed not only in San Francisco but also among the school people of the entire West. Mr. Reed, Mr. McClure, and Mr. Hamilton spoke in behalf of San Francisco. Secretary Shankland reported that he had contracts from both Cleveland

and San Francisco for use of the needed meeting and exhibit halls; and that hotel contracts, guaranteeing 3800 sleeping rooms in Cleveland and 5500 sleeping rooms in San Francisco, were on hand. Mr. Allan reviewed the exhibit facilities of both cities, pointing out that the area in the San Francisco Civic Auditorium was considerably smaller than that of the Cleveland Public Auditorium or of the Atlantic City Auditorium where recent exhibits of the Association had been held. Prolonged discussion followed. On motion of Mr. Anderson, seconded by Mr. Ramsey, it was voted to hold the 1942 convention of the Association in San Francisco.

The annual report of the executive secretary was submitted in writing. It covered in detail the activities of the Association, including the work of its various committees and commissions. It also included a statement of receipts and expenditures for several years past, together with estimates for the year 1941. The report was received and placed on file. On motion of Mr. Reed, seconded by Mr. Ramsey, the budget for 1941, as submitted by the executive secretary, was adopted, with estimated receipts of $64,011.62 and estimated expenditures of $61,469.70.

It was announced that arrangements had been completed for a breakfast in honor of President W. Howard Pillsbury on Wednesday morning, July 2, 1941, during the Boston convention of the National Education Association. It was agreed that Superintendent Carroll R. Reed should be toastmaster at the breakfast, which was to be held at the Hotel Statler.

Mr. Hamilton reported on the National Conference for Cooperation in School Health Education which he attended in New York City as a representative of the American Association of School Administrators immediately following the Atlantic City convention of the Association. The conference was made up of representatives of some forty organizations interested in the field of health education. As a representative group, the Conference has been in existence since 1938. Its main function is to serve as a clearing-house on problems of health education, with a view to avoiding waste and duplication of work. Mr. Hamilton cited the instance of the 1942 yearbook of the American Association of School Administrators on health education. At the time of its inception four organizations were planning yearbooks on the same subject. They gave way to our Association, and several representatives of these organizations became members of our 1942 Yearbook Commission. Mr. Hamilton stated that, since the Conference had no financial support other than the voluntary contributions of the representatives, it was voted to ask each participating organization to contribute $5 annually. On motion of Mr. Anderson, this expenditure was approved. Mr. Hamilton was thanked for his report and was requested to continue as the Association's representative in the health conference.

The report of the executive secretary listed several subjects which had been suggested to the headquarters office for the 1944 yearbook. After some discussion, it was agreed to postpone the selection of the yearbook topic until the fall meeting of the Executive Committee.

President Pillsbury outlined tentative plans for the San Francisco convention program and asked for suggestions. It was the general feeling that San Francisco, with its intimate connections with the Orient, offered opportunity for a colorful program. Mr. Pillsbury stated that the San Francisco people had suggested a Chinese pageant. It was proposed that the entire subject of Pacific relations, as well as of Pan American affairs, should have consideration.

President Pillsbury suggested that Thursday afternoon be set aside for trips in and around San Francisco—for instance to the Chinese schools, the University of California, Stanford University, Mt. Tamalpais, Muir Woods, and the old missions. Mr. Reed felt it would be unwise to crystallize the program too early, since world events might make a change in topics and speakers desirable. Secretary Shankland said that two or more parallel meetings might be needed to accommodate the general sessions.

The fall meeting of the Executive Committee was held at the Stevens Hotel, Chicago, Illinois, October 19-20. Members present were: W. Howard Pillsbury, Schenectady, New York, president; Carroll R. Reed, Minneapolis, Minnesota, first vicepresident; Worth McClure, Seattle, Washington, second vicepresident; J. W. Ramsey, Fort Smith, Arkansas; William J. Hamilton, Oak Park, Illinois; Homer W. Anderson, St. Louis, Missouri; and Stanley H. Rolfe, Newark, New Jersey. Others present were Superintendent Joseph P. Nourse of San Francisco, California, and Executive Secretary Sherwood D. Shankland.

Plans for the seventy-second annual convention to be held in San Francisco, California, February 21-26, 1942, were discussed in detail. The executive secretary stated that reports from the Housing Bureau and other sources indicated a heavy attendance, the principal hotels being reserved to capacity. The opening vesper service will be in two sections, with Bishop Bruce Baxter of the Methodist Church for the Portland Area as the speaker at the War Memorial Opera House, and Superintendent Willis A. Sutton of Atlanta at the Congregational-Methodist Temple. Thirty-three afternoon discussion groups have been organized.

We are confronted with many pressing educational problems affecting young people between the ages of sixteen and twenty-four years. Recent developments in connection with the Selective Service, the Civilian Conservation Corps, and the National Youth Administration have added urgent new questions, while many older ones still remain unanswered. With a view to dealing with this situation as adequately as time will permit, it was voted to organize a seminar on youth problems to meet at San Francisco on the afternoons of Monday and Tuesday of convention week. The findings of this seminar will provide much of the subjectmatter for a symposium on "Education and Youth" at the final general session on Thursday afternoon.

At a recent meeting, the Educational Policies Commission requested the appointment of a committee of the American Association of School Administrators to meet jointly with the Committee on Education of the Chamber of Commerce of the United States with a view to initiating and coordinating a national program for local cooperative efforts between laymen and educators. President Pillsbury announced the appointment of the following committee: Superintendent Alexander J. Stoddard, Philadelphia, Pennsylvania, *chairman;* Superintendent Frank W. Ballou, Washington, D. C.; Executive Secretary Willard E. Givens of the National Education Association; Superintendent David E. Weglein, Baltimore, Maryland; and Superintendent W. Howard Pillsbury, Schenectady, New York.

On motion of Mr. McClure, seconded by Mr. Ramsey, the following resolution was adopted:

> The Executive Committee of the American Association of School Administrators, a department of the National Education Association of the United States, believes that the school administrators, schoolboards, and teachers of the nation desire to cooperate to the fullest extent with the national defense authorities. The necessity for diverting scarce materials into essential defense industries is clearly recognized.
>
> It is hoped that the children and youth in the schools may be guarded as far as possible by the Office of Production Management against any

> educational handicaps due to shortages in material and equipment necessary to efficiency in teaching. The Executive Committee urges the careful consideration of school needs by the Office of Production Management in granting priorities, and expresses the hope that in these considerations there will be continued consultation and cooperation with the United States Office of Education.
>
> The Executive Committee offers the facilities and services of the American Association of School Administrators in any practical way that can be of aid to the government in its defense work.

On motion of Mr. Anderson, seconded by Mr. Reed, an action committee consisting of Superintendent David E. Weglein, Baltimore, Maryland; Business Manager H. A. Allan of the National Education Association; and Superintendent Charles H. Lake, Cleveland, Ohio, was appointed to cooperate with the Office of Production Management, the United States Office of Education, and other interested agencies in matters dealing with priority listings for school supplies and equipment.

The executive secretary stated that five topics for the 1944 yearbook had been suggested as follows: School Administration and Public Relations; Expanding the Child's Experience Curriculum; Recreation thru the School; The Textbook—Selection, Use, and Abuse; and Character Education. Brief outlines of proposed subjectmatter accompanied each topic. After discussion and careful consideration, it was voted that the 1944 yearbook should concern itself with matters in the field of education for citizenship, character, and national morale. On motion of Mr. Reed, seconded by Mr. McClure, President Pillsbury was authorized to appoint a commission of nine members to prepare the yearbook. Each member of the Executive Committee agreed to submit a brief memorandum or topic outline embodying his ideas of the type of material which should be considered by the yearbook commission.

There was presented and read to the meeting a proposal for a national educational policies commission drafted by a special committee of the American Council on Education, which met at Skytop, Pennsylvania, in July 1941. In brief, it was proposed that the American Council on Education, the National Education Association, and the American Association of School Administrators sponsor a national educational policies commission to be composed of fifteen persons chosen from the profession of education and six persons from outside the profession.

At a recent meeting of the Executive Committee of the National Education Association, it was voted to accept the general recommendation of the Skytop meeting and to invite the American Council on Education to become a third sponsoring group of the existing Educational Policies Commission of the National Education Association and the American Association of School Administrators. This action was accompanied by the following clarifying statement:

> The Executive Committee of the National Education Association believes that in doing this we should follow the general policies and procedures already established. Our Executive Committee, therefore, recommends that the two Executive Committees invite the Executive Committee of the American Council on Education to become a third sponsoring group to work jointly with our two Executive Committees in carrying forward the work of the Educational Policies Commission; that the Executive Committee of the American Council on Education be given the opportunity of making eight or more nominations for filling the first four vacancies on our Educational Policies Commission; that when these nominations are made, the three Executive Committees jointly select from such nominees the four individuals to fill these vacancies, and that when vacancies occur in the Educational Policies Commission thereafter, that the three Executive Committees, acting together, make the nominations and elect the members to fill the vacancies.
>
> It is recommended that the Executive Committee of the American Council on Education be asked to contribute $5000 per year toward the operation of the Educational Policies Commission. This request is made with the understanding that the American Council would be free to seek such other funds for the use of the Educational Policies Commission as it desires

On motion of Mr. McClure, seconded by Mr. Hamilton, it was voted to approve the proposal to invite the American Council on Education to become a third sponsoring group of the Educational Policies Commission and to accept as a working basis the statement of the Executive Committee of the National Education Association.

The Finances

The Department closed the year 1941 with a balance in the regular fund of $18,551.84. The balance one year ago was $14,765.90. Two years ago it was $13,334.45. The principal source of revenue is the annual membership fee of five dollars. The Department enrolled 1,263 members in 1922; 3,114 in 1927; 4,013 in 1931; 3,110 in 1933; and 4,470 in 1941. The membership distribution by states for the last six years is shown in Table 1.

By agreement with the National Education Association, the net income from the exhibits at the winter meeting is divided equally between the Department and the parent Association, each organization thus deriving funds for convention expenses. The active work of organizing and managing the exhibits is done by the Business Division of the National Education Association. The amounts which the Department has derived from this source during recent years are as follows:

1926—Washington	$6,830.68
1927—Dallas	8,524.64
1928—Boston	8,883.87
1929—Cleveland	14,687.26
1930—Atlantic City	17,485.71
1931—Detroit	16,502.51
1932—Washington	12,903.39
1933—Minneapolis	9,061.75
1934—Cleveland	8,288.50
1935—Atlantic City	13,511 03
1936—St. Louis	16,044.82
1937—New Orleans	16,184.67
1938—Atlantic City	19,441.51
1939—Cleveland	20,293.10
1940—St. Louis	18,900.98
1941—Atlantic City	22,666.62

The statement of receipts and expenditures which follows covers the calendar year 1941. It includes expenses of the Atlantic City convention, some preliminary charges for the San Francisco convention, and all items of general expense. All bills were paid at the end of the year. A detailed statement regarding the Permanent Educational Research Fund is given elsewhere in this report.

Regular Receipts during Calendar Year 1941

Annual dues, 3,856 members, 1941	$19,280 00	
Annual dues, 426 members, 1942	2,130.00	
Interest—Permanent Research Fund	1,474.84	
Yearbooks sold	7,411.29	
Atlantic City exhibit	22,666.62	
Educational Research Service	11,888.75	
Other income	63.79	
Total receipts		$64,915.29
Balance, January 1, 1941		14,765.90
Grand total		**$79,681.19**

Regular Expenditures during Calendar Year 1941

Atlantic City Convention:

Registration	$539.41	
Programs	672.44	
Badges	192.06	
Stenotype report	295.31	
President's expense	173.31	
Secretary's expense	148.47	
Group meetings	94.90	
Music	580.65	
Expense for speakers	2,363.16	
Summarization and appraisal	977.51	
Publicity	91.13	
Projection	10.75	
Madrigal Singers and Orchestra	980.00	
Total Atlantic City Convention		$7,119.10

General Expense:

Salaries, administrative unit	$13,938.00	
Printing 9M Nineteenth Yearbooks	5,188.19	
Printing 6M Atlantic City Official Reports	1,673.47	
Printing Research Bulletins, 5 issues	763.72	
Other printing	1,829.05	
Postage, express, and stationery	4,427.68	
Mimeographing, multigraphing, typing, etc.	1,067.98	
Telephone and telegraph	273.93	
President's expense	686.93	
Secretary's expense	507.28	
Executive Committee expense	2,214.92	
Advisory Council	55.00	
Audit Committee	74.70	
Board of Tellers	157.71	
1942 Yearbook Commission expense	3,220.74	
1943 Yearbook Commission expense	1,889.25	
Bad debts and worthless checks	194.63	
Educational Research Service, salaries	8,763.86	
Educational Research Service, miscellaneous	3,496.65	
Retirement fund	952.14	
Supplies and equipment	188.41	
Surety bonds	20.00	
Educational Policies Commission	2,000.00	
San Francisco convention, advance expense	326.01	
American Council on Education	100.00	
Total general expense		$54,010.25
Total expense for the year		$61,129.35
Balance, December 31, 1941		18,551.84
Grand total		**$79,681.19**

TABLE 1.—MEMBERSHIP BY STATES FOR THE YEARS 1936-1941 AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS

formerly the Department of Superintendence

State	1936 St. Louis	1937 New Orleans	1938 Atlantic City	1939 Cleveland	1940 St. Louis	1941 Atlantic City
Alabama	47	52	52	55	66	61
Arizona	23	23	23	25	24	23
Arkansas	36	35	32	31	45	36
California	109	136	144	144	150	153
Colorado	57	53	51	48	59	60
Connecticut	59	66	81	76	71	92
Delaware	23	23	23	20	19	25
District of Columbia	59	62	64	69	71	66
Florida	16	31	22	22	17	21
Georgia	41	61	63	63	63	63
Idaho	8	9	12	9	8	10
Illinois	333	290	300	328	352	331
Indiana	119	104	103	106	114	101
Iowa	91	83	74	93	107	82
Kansas	85	90	86	98	115	95
Kentucky	56	56	51	58	56	49
Louisiana	29	78	51	52	47	43
Maine	21	27	27	27	22	23
Maryland	47	52	64	63	69	76
Massachusetts	139	162	190	169	161	174
Michigan	171	183	200	219	223	231
Minnesota	102	90	87	110	110	99
Mississippi	38	63	38	41	44	40
Missouri	232	152	146	139	184	140
Montana	17	19	16	15	13	15
Nebraska	50	47	43	46	57	48
Nevada	4	3	4	4	3	4
New Hampshire	28	31	32	28	30	37
New Jersey	201	215	277	249	234	287
New Mexico	18	22	20	22	29	18
New York	372	379	448	424	379	417
North Carolina	42	47	65	56	60	63
North Dakota	19	12	17	15	15	16
Ohio	202	214	230	266	261	251
Oklahoma	67	70	61	60	60	55
Oregon	16	16	15	21	25	29
Pennsylvania	268	271	345	353	334	401
Rhode Island	38	39	42	37	38	42
South Carolina	21	44	39	37	36	37
South Dakota	23	23	20	21	24	15
Tennessee	54	49	39	40	43	44
Texas	226	269	240	227	244	227
Utah	28	26	26	24	25	24
Vermont	20	25	28	27	26	24
Virginia	45	51	61	62	61	75
Washington	20	31	23	26	27	28
West Virginia	40	35	51	53	47	46
Wisconsin	126	118	128	136	131	129
Wyoming	12	12	12	13	14	13
Alaska	1	1	2	2	3	1
Bahamas	...	...	...	...	1	1
Canada	8	7	13	13	11	11
Canal Zone	...	1	2	1	1	2
China	1	1	1	1	...	...
Hawaii	3	2	3	2	2	1
India	...	1	...	1	1	...
Iraq	1	1	1	1	...	1
Mexico	1	1	1	...	1	...
Philippine Islands	5	3	3	4	2	6
Puerto Rico	7	6	6	6	4	8
Scotland	...	...	...	1	...	...
Virgin Islands	...	...	1	...	...	...
Total	3,925	4,073	4,299	4,359	4,439	4,470

NOTE: The count includes 4,284 members who paid dues for the year 1941, 9 honorary members, 174 life or twenty-five-year members, and 3 six-year members.

Permanent Educational Research Fund

In April 1927 the Commission on the Curriculum recommended the appointment of a Committee on Financing Educational Research. The Boston convention a year later took favorable action on the proposal and directed the Committee to make plans for creating a fund that should yield an annual income sufficient to enable the Department to carry on important studies in education on a nation-wide basis.

In the fall of 1929 the Committee, under the chairmanship of Randall J. Condon, undertook a vigorous campaign to secure contributions for the Permanent Educational Research Fund. Almost at the same time the stock market collapsed and the ensuing financial depression so hampered the undertaking that it was necessary to postpone the general campaign.

In connection with this campaign, a number of members took out ten-year endowment insurance policies in the amount of $250 each. The last of these policies matured in 1941. Altogether, nineteen such policies were paid in full. Those who kept up their payments on these policies during ten years of depression are entitled to high commendation.

The schools of Dallas, Texas, likewise merit special mention. Superintendent Condon was enthusiastic about that city, and it was ever loyal to him. It entertained our convention in 1927, when he was president of the Department of Superintendence. When Mr. Condon appealed for contributions to the Permanent Educational Research Fund, Dallas was glad to respond promptly. Many of its schools took out subscriptions of $100 or more, to be paid in ten annual instalments. Now, twenty-three schools have paid in full. The names of these schools are printed in the list of members in the back of this yearbook. No other city school system in the United States can compare with Dallas in memberships.

Additions to the principal of the Fund during 1941 amounted to $3,773.48. The Board of Trustees of the National Education Association reports assets in the investment account to the credit of the Permanent Educational Research Fund on December 31, 1941, as follows:

	Par Value	*Book Value*
U. S. Treasury Savings Bonds due 1946	$3,000 00	$2,250 00
U. S. Treasury 3¼% Bonds due 1943-45	50 00	50.00
U. S. Treasury 3¼% Bonds due 1944-46	150.00	150.00
U. S. Treasury 2⅞% Bonds due 1955-60	150 00	150 00
U. S. Treasury 2¾% Bonds due 1956-59.	3,000.00	3,092.28
South Carolina Highway Certificate of Indebtedness 4¾% due 1946	2,000.00	2,077 28
Newport News City Street Improvement and Sewerage Construction Bonds 5½% due 1950	11,000 00	11,285.00
Portsmouth, Virginia, Waterworks Bonds 5% due 1948	3,000.00	3,160.51
Port of New York Authority 3% Bonds due 1976	2,000.00	2,017.50
City of New York Corporate Stock 3% due 1980	500.00	498 75
Cash on hand		6,588.23
Total		$31,319.55

The following statement shows the assets at the beginning of the year, together with the cash receipts during 1941 of the Permanent Educational Research Fund:

Assets on hand, January 1, 1941	$27,546.07
Life memberships—cash payments	270.00
Proceeds, 10-year endowment insurance policies·	
W. W. Charters.	270 34
W. W. Coxe	289.26
Esther R. Wilber	303.75
P.T A.'s of Edgemont and Watchung Schools, Montclair, N. J.	283 43
Teachers of Edgemont and Watchung Schools, Montclair, N J	283.43
Edgemont and Watchung School Funds, Montclair, N. J.	283.43
Johnson City, N. Y., Teachers Association	277.02
Glen Rock, N. J., Public Schools	288.04
Harold A. Ferguson	284.77
P. T. A. of Montclair High School	284.77
Bridgeton, N. J., Public Schools	275.62
LeRoy, N. Y., Teachers Association	274.62
Dallas, Texas, schools by L. V. Stockard, assistant superintendent:	
T. G. Terry School by Margaret Grady, principal	10 00
Stephen J. Hay School by J. Frank Turner, principal	10.00
Cumberland School by Alfred J. Loos, principal.	10 00
Richard Lagow School by R. C T. Jacobs, principal	10.00
William B. Travis School by M. H. Morris, principal	30 00
James Stephen Hogg School by Mary Sellers, principal	10.00
Hackensack, N. J., Board of Education	25.00
Assets as of December 31, 1941	$31,319 55

The Educational Research Service

On December 29, 1940, the President of the United States declared that this country "must be the great arsenal of democracy. For us, this is an emergency as serious as war itself." As the defense program of the national government gained momentum it became apparent that every activity of social and economic life would be affected. During 1941 the schools were called upon to assume new responsibilities as well as greatly increased burdens, not only in defense training plans but also in civic education and the promotion of civilian morale. In view of the importance of the schools as an agency of national defense, many administrators and educational groups look to the Educational Research Service as a means of keeping them informed of developments, both in Washington and in the field. This confidence has resulted in a steady increase in the number of subscribers to the Service as shown by Table 2.

TABLE 2.—EDUCATIONAL RESEARCH SERVICE SUBSCRIBERS AND INCOME FROM SUBSCRIPTIONS

Year	Number of subscribers	Cash receipts from subscribers
1	2	3
1924	40	$ 525.00
1925	131	2,555.00
1926	177	3,325.00
1927	213	5,790 00
1928	245	6,225 00
1929	271	6,362 00
1930	323	8,112.50
1931	338	8,100 00
1932	324	7,443.75
1933	319	7,514.58
1934	346	8,496.75
1935	359	8,714.56
1936	369	9,254 17
1937	408	9,887 82
1938	445	10,800 44
1939	445	10,460.42
1940	468	11,662 50
1941	483	11,888.75

Altho established primarily to meet the needs of city school systems, the Service now includes in its list of subscribers state departments of education, colleges and universities, teachers associations, and other agencies. Maintained jointly by the American Association of School Administrators and the Research Division of the National Education Association, this special information service is supported by a twenty-five dollar annual fee. In return subscribers receive publications dealing with problems in school administration and are assured of individual attention in response to requests for information.

Studies prepared for the Service in 1941 and issued as circulars included the results of a survey of class size in 273 school systems in cities of all population levels; a bibliography of questionnaire studies reported to the Service during 1941; a comparison of school and city expense based on United States Bureau of the Census data; salary schedule provisions for regular classroom teachers in effect in 1940-41; and bimonthly abstracts of articles on education which have appeared in lay magazines. Other materials sent subscribers included the yearbook and *Official Report* of the American Association of School Administrators, the biennial salary tabulations compiled by the Research Division, and reports and bulletins of various committees and departments of the National Education Association and of certain outside agencies.

Requests for information cover a wide range of topics. Administrative problems stressed in recent correspondence have included policies and practices affecting school employees, especially salary payments, sick leave, tenure, and retirement provisions; comparative school costs; structural and functional organization of schools; records and reports; and trends in the school curriculum. These letters of inquiry are answered by sending pertinent materials and by preparing special memorandums, tabulations, and lists of references. Studies secured thru the questionnaire exchange provide additional information. The research and information facilities of government and private agencies located in Washington are also utilized, thus enabling subscribers to draw upon nationwide experience in the solution of local problems.

The Audit Committee

The books and accounts of the American Association of School Administrators are audited twice each year. In June, certified public accountants make a complete examination of the finances of the National Education Association, including all its departments. The constitution of the American Association of School Administrators also requires that a committee of three members of the Department shall audit the accounts at the close of each fiscal year. The constitution further provides that its fiscal year shall correspond with the calendar year. The report of the Audit Committee for the year ended December 31, 1941, will be printed in full in the *Official Report* of the 1942 convention. The members of the Committee are: Associate Superintendent Louis Nusbaum, Philadelphia, Pennsylvania, *chairman;* Superintendent Jesse H. Binford, Richmond, Virginia; and Superintendent Ray E. Cheney, Elizabeth, New Jersey.

Publications

The three major activities of the American Association of School Administrators are the annual convention, the Educational Research Service, and the publication of the yearbook. The first yearbook of the Department of Superintendence was a small, paper-bound volume entitled *The Status of the Superintendent.* Superintendent John H. Beveridge of Omaha, Nebraska, who was then president of the Department, originated the idea and in spite of financial difficulties succeeded in having the first yearbook ready for distribution at his convention in Cleveland in February 1923. The series thus begun has continued unbroken for two decades.

The nineteenth yearbook, *Education for Family Life,* was distributed to members at the time of the Atlantic City convention last February. Such a yearbook would have been unthought-of fifty years ago. Today the school not only must teach reading, writing, and arithmetic, but also it must concern itself with many other activities brought about by changing social conditions. The automobile put safety education into the schools. The home and the church have gradually made increasing demands on the schools in the fields of citizenship, character, and morale building. The White House Conference on Child Health and Protection, called by President Hoover, forcibly reminded the public of its new responsibilities to children and youth, brought about to a considerable extent by rapidly changing modern home conditions. The yearbook on family life is, in effect, a plea for educators to rethink school activities with the needs and aspirations of home life in mind.

The present yearbook, *Health in Schools,* was authorized in 1939. The members of the commission, appointed by President Ben G. Graham, represent a good cross section of those groups which are particularly concerned with matters of health. Four commission meetings have been held. Each member of the commission drafted one or more chapters which were read aloud, reviewed, and revised at the meetings. The completed volume represents the considered judgments of the entire commission.

The 1943 yearbook will deal with the problems of youth between the ages of sixteen and twenty-four years. At the first commission meeting in Chicago it was agreed to include chapters on such topics as: Learning To Work; Making Occupational Choices; Making the Transition from School to Work; and Coordinating School with Community and Governmental Agencies. The following persons, appointed by President Carroll R. Reed, are preparing the yearbook: DeWitt S. Morgan, superintendent of schools, Indianapolis, Indiana, *chairman;* Edmund deS. Brunner, professor of education, Teachers College, Columbia University; Paul L. Essert, superintendent of schools, Grosse Pointe, Michigan; Herold C. Hunt, superintendent of schools, Kansas City, Missouri; Paul B. Jacobson, principal, University of Chicago High School; Claude L. Kulp, superintendent of schools, Ithaca, New York; Charles H. Lake, superintendent of schools, Cleveland, Ohio; Edwin A. Lee, dean, School of Education, Univer-

1942 Yearbook Commission in session at Chicago, Illinois, October 4, 1941 sity of California at Los Angeles; and Barbara H. Wright, supervisor of counselors, public schools, Minneapolis, Minnesota.

The preparation of a yearbook is not an easy task. A commission of about nine members is at work for two years. The members serve without pay, their only reward being the satisfaction of work well done. Ordinarily four commission meetings, each covering a period of three or four days, are held. After an outline has been worked out and chapter headings selected, each member assumes responsibility for preparing the first draft of a chapter in an area which he is especially qualified to discuss. Naturally, there is much overlapping and lack of unity. Discussion at succeeding meetings usually brings adjustment and agreement. We are especially indebted to Frank W. Hubbard, director of the Research Division of the National Education Association, for his able assistance. He is responsible for conducting research, collecting facts, and editing the manuscripts in final form for printing.

The *Summary* of the Atlantic City convention was ready for distribution at the closing session and was mailed to all members of the American Association of School Administrators on the following day. About three weeks later the *Official Report* of the convention was published and delivered to members. It was a 199-page volume. Five issues of the *Research Bulletin* of the National Education Association were mailed to members during the year. The titles of these bulletins were: Status of Teacher Retirement; Salaries of City School Em-

TABLE 3.—YEARBOOKS OF THE DEPARTMENT

Year	Title	Number copies printed	Cash sales of all yearbooks for the year
1923	The Status of the Superintendent	3,200	$ 142 45
1924	The Elementary School Curriculum	4,500	1,364 13
1925	Research in Constructing the Elementary School Curriculum	11,000	4,707 65
1926	The Nation at Work on the Public School Curriculum	12,000	8,467 94
1927	The Junior High School Curriculum	11,000	8,844.57
1928	The Development of the High School Curriculum	10,000	9,830 58
1929	The Articulation of the Units of American Education	11,000	7,842.51
1929	Reprint of 1926 Yearbook	4,000	....
1930	The Superintendent Surveys Supervision	11,348	10,603 43
1931	Five Unifying Factors in American Education	11,572	8,375 87
1932	Character Education	12,000	10,053 94
1933	Educational Leadership	8,000	4,922 85
1934	Critical Problems in School Administration	7,000	5,021 13
1935	Social Change and Education	9,000	7,844.99
1936	The Social Studies Curriculum	14,000	9,128.17
1937	Improvement of Education: Its Interpretation for Democracy	9,000	6,965 99
1938	Youth Education Today	11,000	6,789 56
1939	Schools in Small Communities	9,000	5,483 96
1940	Safety Education	11,000	8,894 92
1941	Education for Family Life	9,000	7,411.29

ployees, 1940-41; School Costs and State Expenditures, 1930-1939; High-School Methods with Superior Children; and Schools and the 1940 Census. As usual, the members received the *Classified List of Educational Periodicals* and two issues of the Radio Calendar.

Educational Policies Commission

During the dark days of the winter of 1932-33 the need for united effort and active leadership in defense of the schools was apparent. The appointment of the Joint Commission on the Emergency in Education was the profession's practical answer to this need. This Commission, sponsored jointly by the Department of Superintendence and the National Education Association, had no machinery and no salaries of its own. It worked thru existing agencies. The loyal cooperation of state and national educational organizations was a large factor in promoting its work.

At the Denver convention of the National Education Association in July 1935, the Joint Commission made its final report, in which it recommended the organization of an Educational Policies Commission to develop a constructive program for the continuous self-appraisal of the American system of education, to suggest means whereby changes for the improvement of our educational institutions might be more speedily accomplished, and to stimulate such improvement. Steps were promptly taken to put this recommendation into effect.

The Educational Policies Commission was organized in the fall of 1935 by joint action of the National Education Association and the Department of Superintendence. It was composed of twenty members selected by the Executive Committees solely on the basis of ability to contribute significantly to the solution of the problems confronting education in America. Appointments were for a five-year period ending December 31, 1940. Financing was possible by aid of a grant of $250,000 from the General Education Board, payable in five annual instalments of $50,000 each.

In December 1940, action was taken reorganizing the Educational Policies Commission for a four-year period beginning January 1, 1941. For the year 1941 a budget of $35,000 was provided, apportioned as follows: $13,000 from the National Education Association; $2000 from the American Association of School Administrators; and $20,000 from the General Education Board.

As stated elsewhere in this report, the Executive Committee has under advisement the proposal which originated at the Skytop meeting of the American Council on Education to substitute for the present Educational Policies Commission a new group to be known as the National Educational Policies Commission, sponsored jointly by the American Council on Education, the National Education Association, and the American Association of School Administrators. The attitude of the General Education Board toward this proposal was stated in a letter dated December 12, 1941, as follows:

> It is our understanding that the American Council on Education, the National Education Association, and the American Association of School Administrators, thru their Executive Committees, have each declared interest in the setting up of a National Educational Policies Commission to replace the present Educational Policies Commission, but that the precise composition of the new Commission, how its members should be chosen, the functions it should endeavor to serve, and the financial contributions of the parent bodies remain to be decided in a joint meeting of the Executive Committees of the three bodies. If possible, we should like to have an indication of the year to year budget of the proposed new Commission, showing how it will be provided, what each of the three groups at interest will contribute, and also the essential cost factors which the budget is expected to meet.
>
> The Board, having made a terminal grant to the Educational Policies Commission, will naturally wish to be clear as to the distinctively new features in the proposed Commission which will differentiate it from the present Commission A mere enlargement of the present Commission would presumably not constitute a basis for further assistance by our Trustees in view of their considered action when the terminal grant was made. I may say, however, that a proposal looking toward the establishment of a voluntary agency that will be truly representative of American education and which will be in position to clarify major educational issues, formulate policies and make pronouncements regarding desirable educational development in this country, would undoubtedly receive careful consideration by our Executive Committee.

Final action on the proposal will be taken at the next meeting of the Executive Committee.

The Educational Policies Commission recently issued a document entitled *The Civilian Conservation Corps, the National Youth Administration, and the Public Schools.* Acting at the request of the conference of superintendents of schools in cities with population over 200,000, President W. Howard Pillsbury appointed a committee to assist in carrying out the recommendations of the report. The committee consists of the following superintendents of schools: A. L. Threlkeld, Montclair, New Jersey, *chairman;* James L. Hanley, Providence, Rhode Island; H. M. Ivy, Meridian, Mississippi; Claude L. Kulp, Ithaca, New York; and Alexander J. Stoddard, Philadelphia, Pennsylvania.

National Defense

Pearl Harbor and its aftermath have taken World War II out of the realm of newspaper headlines and radio broadcasts and put it as a grim reality into every American activity, including the schools. The generation born before the turn of the century had a goodly heritage marked by peace, plenty, and high ambition. It can scarcely be claimed that we handed it on unimpaired.

Youth of today were reared in an era of doubt, disillusionment, and the worship of material things. Now they are suddenly called to defend the ideals and hopes of free men everywhere. Our sailors and soldiers are not long out of school and college. In a list three columns long of those killed in action, one was reported as twenty-seven years of age. All the rest were younger. They face perils of land and sea and air such as no fleets or armies ever before encountered. They endure privation, wounds, and death. It is the job of all of us still at home to do our utmost to keep them supplied with food, clothes, rifles, planes, and ships. Above all, they are entitled to know that behind them is a united and understanding nation.

The time has come for clear and courageous thinking, for the end of petty controversy, and for decisive action. Schools have no small part to play.

They are our boys—products of American education. It is my hope that we may do as well by them as they are doing by us.

Respectfully submitted,

SHERWOOD D. SHANKLAND
Executive Secretary

LIST OF MEMBERS

The American Association of School Administrators

A Department of the

National Education Association of the United States

Corrected to December 12, 1941

A

Aaron, Sadie, B A '25, Stanford Univ.; M.A.'29, Tchrs. Col., Columbia Univ., Psychologist, Pub. Sch , Houston, Texas, since 1929

Abbett, Merle J , A B.'07, Franklin Col.; A.M.'18, Tchrs. Col., Columbia Univ.; Supt. of Sch., Admin. Bldg., Ft. Wayne, Ind , since 1932

Abbot, Julia Wade, B.S.'23, Tchrs Col , Columbia Univ.; Dir., Early Childhood Educ., Admin. Bldg , The Parkway at 21st, Philadelphia, Pa., since 1924.

Abbott, Forrest L., B S. in Ed.'29, Southwest Mo State Tchrs. Col , Springfield, Mo ; M A.'34, Tchrs. Col , Columbia Univ.; Head, Comml Dept , H. S , Montclair, N. J., since 1934

Abbott, Pansy Jewett, M A '31, Stanford Univ ; Co Supt. of Sch., Redwood City, Calif , since 1925

Abbott, Robert B., Vice-Prin., Oakland H. S , Oakland, Calif.

Abbott, Warren W., Supt. of Sch., Keego Harbor, Mich.

Abell, J. A., A.B.'10, A M.'14, Ind. Univ.; Supt. of Sch , Nappanee, Ind., since 1923

Abernethy, Robert R., Diploma '15, Keystone State Normal Sch., Kutztown, Pa.; B S '23, Muhlenberg Col.; M A '25, Univ. of Pa.; Supt. of Sch , Harrisburg, Pa., since 1935.

Abernethy, Walter E., A.B.'22, Lenoir-Rhyne Col.; M.A '29, Univ. of N. C.; Supt. of Sch., Shelby, N. C., since 1936.

Ackley, Clarence E , A B.'10, A M '13, Oberlin Col ; Ph D.'33, Univ. of Pittsburgh; Secy , State Council of Educ. and Deputy State Supt. of Pub Instr., Harrisburg, Pa , since 1935

Ackley, E. L , A B. and A M '05, Pd.B.'08, Syracuse Univ , Supt. of Sch., Johnstown, N Y., since 1910

Adams, Edwin W , B S.'14, Temple Univ.; M.A.'22, Univ of Pa.; Ed D '28, Temple Univ.; Assoc Supt. of Sch , Philadelphia, Pa , since 1930

Adams, Henry L , B.S '20, Colgate Univ ; M.A '26, Pa. State Col.; Supt. of Sch., Seymour, Conn., since 1937.

Adams, Karl Langdon, Diploma in C.E.'08, B.S.'09, Ohio Univ.; M.A.'29, Tchrs. Col , Columbia Univ ; Pres., Northern Ill. State Tchrs. Col., De Kalb, Ill., since 1929.

Adams, L. W., A.B '14, Grove City Col.; A.M.'36, Tchrs. Col , Columbia Univ., Supt of Sch., Anoka, Minn., since 1928.

Adams, Philip R., A B., Stanford Univ.; M.S., Univ. of Southern Calif.; Prin., Woodrow Wilson, Jr. H. S., Glendale, Calif., since 1939.

Adams, Ray H., A.B.'27, M.A.'28, Univ. of Mich.; Supt. of Sch., Dearborn, Mich., since 1916

Adams, Robert, Jr., B S.'27, Alfred Univ ; M Ed.'31, Rutgers Univ.; Prin , H. S., Scotch Plains, N. J., since 1941.

Adams, Ruby M., B.S.'25, M.A '29, Tchrs. Col , Columbia Univ.; Dir. of Elem. Educ., Pub. Sch , Schenectady, N. Y., since 1935.

Adcock, E. L , Bus. Mgr., Pub. Sch., 624 Lamar St., Knoxville, Tenn., since 1924.

Addicott, Irwin O., A.B.'22, Univ. of Calif.; M A.'24, B.D.'25, Pacific Sch. of Religion; Ed.D.'39, Stanford Univ.; Prof. of Educ. and Prin. of Tr. Sch., Univ. of Denver, Denver, Colo., since 1939.

Ade, Lester K , B.A.'21, M.A.'24, Bucknell Univ.; Ph.D.'31, New York Univ.; M.A.'32, Yale Univ.; LL.D.'35, Bucknell Univ.; Litt D.'36, Temple Univ , L.H.D.'38, Beaver Col ; Sr. Specialist on Sch Facilities, U. S Office of Educ., 785 Market St., San Francisco, Calif., since 1941.

Adkins, Stanley, A.B '10, Ohio State Univ.; M.A '35, Tchrs Col., Columbia Univ.; Supt. of Sch., Ely, Minn , since 1935.

Adkinson, Ray, B.A.'18, Pomona Col.; Co. Supt. of Sch., Santa Ana, Calif., since 1931.

Aikins, Frederick H., B S '17, Univ. of Maine; M Ed.'37, Bates Col.; Supt. of Sch., South Windham, Maine, since 1926.

Aker, Homer Ferris, B.S.'16, Oregon State Col.; Supt. of Sch., Imperial, Calif., since 1940.

Akerly, Harold E , B.S.'08, Univ. of Rochester; S.B.'10, Mass. Inst. of Tech.; M A.'33, Univ. of Rochester, Asst. Supt. of Sch , 13 Fitzhugh St., S., Rochester, N. Y., since 1929.

Akin, William Porter, B.S.'20, Southern Methodist Univ.; M A.'26, Univ. of Texas; Dean, Texarkana Col., Texarkana, Texas, since 1927.

Akridge, Garth H., B.S. in Ed '31, Ark. State Tchrs. Col., Conway, Ark.; M.A.'32, Ph.D. '37, Tchrs. Col., Columbia Univ.; Dir. of Voc Educ , Sch. Admin. Bldg., 275 N. W. Second St, Miami, Fla., since 1940.

Albergotti, William M , B S '21, The Citadel; M.A.'30, Wofford Col.; Supt. of Sch , Greer, S. C., since 1935.

Albers, Martin Z., A.B.'15, Hope Col.; A.M '19, Des Moines Col.; Co. Supt. of Sch., Eldora, Iowa, since 1936.

Albright, Denton M., A.B.'15, Albright Col.; A.M.'22, Columbia Univ.; Supt. of Sch , Crafton, Pa., since 1938.

Alexander, Carter, B.S.'05, A B.'06, A.M.'08, Univ. of Mo.; Ph.D.'10, Columbia Univ.; Library Prof., Tchrs. Col., Columbia Univ., New York, N. Y , since 1932.

Alexander, E. L., A.B.'35, Shurtleff Col.; M.A '37, Wash. Univ.; Supt. of Sch., Edwardsville, Ill., since 1937.

Alfonso, Sister M., 75 Post Ave., Westbury, L. I., N. Y.

Alger, John Lincoln, A.B.'90, A.M.'95, Brown Univ.; Ed.D.'21, R. I State Col.; Sc.D.'38, R. I. Col. of Pharmacy; Pres. Emeritus, R. I. Col. of Educ., Providence, R. I., since 1939.

Allan, Harold A., A.B.'06, Bates Col.; Dir., Business Div, Natl. Educ. Assn., 1201 16th St., N. W., Washington, D. C., since 1923.

Allbaugh, Edgar B., Diploma '01, State Tchrs. Col, Emporia, Kansas; Supt. of Sch., Concordia, Kansas, since 1929.

Alleman, Sam A., A.B.'98, La. State Univ.; Parish Supt. of Sch., Napoleonville, La., since 1905.

Allen, C. J., Diploma '30, State Tchrs. Col., Jacksonville, Ala.; B.S.'31, M.A.'33, Univ. of Ala.; Co. Supt. of Sch., Anniston, Ala., since 1932.

Allen, Charles Moore, M.S.'36, Univ. of Ill.; Dir. of Student Work and Related Tr., NYA, 222 W. North Bank Drive, Chicago, Ill.

Allen, David G., M.Ed.'38, St. Lawrence Univ.; Supvg. Prin. of Sch., Lake Placid, N. Y., since 1934.

Allen, Frank E, A.B.'16, A.M.'23, Ind. Univ.; Supt. of Sch, South Bend, Ind, since 1931.

Allen, Howard A., B.A.'16, Morningside Col; Prin., W. H. Adamson H. S., Dallas, Texas, since 1935.

Allen, J. O., M.A.'20, Univ. of S. C.; Supt. of Sch., Albany, Ga., since 1937.

Allen, Lyman Richards, B.S.'98, Harvard Univ.; A.M.'20, Columbia Univ; Union Supt. of Sch., Framingham, Mass., since 1929.

Allen, Richard D., A.B.'10, A.M '12, Ph.D.'21, Brown Univ.; Asst. Supt. of Sch., 20 Summer St., Providence, R. I., since 1918.

Allman, H. B, B S '10, Tri-State Col.; M.A.'31, Ind. Univ.; Supt. of Sch., Muncie, Ind., since 1936.

Allman, John I., B.S. in Ed.'29, Mercer Univ.; M.A.'31, Tchrs. Col., Columbia Univ.; Asst. State Supt. of Sch., State Capitol, Atlanta, Ga., since 1941.

Almack, John C., B.A.'18, M.A.'20, Univ of Oregon; Ph.D.'22, Stanford Univ.; Prof. of Educ., Stanford Univ., Stanford University, Calif., since 1921.

Aloysia, Mother M., Ph.D.'26, Fordham Univ.; Pres., Good Counsel Col., White Plains, N. Y., since 1923.

Altstetter, M. L., A.B.'09, M.A.'27, Ohio State Univ.; Ph.D.'29, George Peabody Col. for Tchrs.; Prof. of Educ., Univ. of Tenn., Knoxville, Tenn., since 1939.

Alverson, G. Carl, A.B.'06, D.Ped.'29, St. Lawrence Univ.; Supt. of Sch., Syracuse, N. Y., since 1927.

Alvey, Edward, Jr., B.A.'23, M.A.'28, Ph D.'31, Univ. of Va.; Dean, Mary Washington Col., Fredericksburg, Va, since 1934.

Ambrose, Rell A, M.A '33, Univ. of Mich; Supt. of Sch, Carson City, Mich., since 1924.

Ambruster, John Rea, B.S '17, M.S.'28, Univ. of Ill.; Prin, The Greendale Sch., Greendale, Wis., since 1938.

Ames, Verson S., A B.'04, Colby Col.; Supt. of Sch, Wilton, N. H., since 1923.

Amidon, Edna P., B.S.'19, M.S.'27, Univ. of Minn.; Chief, Home Economics Educ. Serv., U S Office of Educ., Washington, D. C., since 1938.

Amidon, Paul S., B.S.'24, M.A '34, Univ. of Minn.; Supt. of Sch., St. Paul, Minn, since 1936.

Andersen, C. T., A.B. and M.A.'26, Univ of Mich; Asst. Secy, Bd. of Educ 1354 Broadway, Detroit, Mich., since 1940.

Anderson, A. B, B.S. in Ed.'27, N. Dak. State Col.; Supt. of Sch., Salmon, Idaho, since 1936.

Anderson, A. Helen, A.B.'14, A M.'31, Univ. of Denver; Supvr. of Publications, Pub. Sch., 414 14th St., Denver, Colo., since 1929.

Anderson, C. S., A.B.'19, Phillips Univ.; Supt. of Sch., Porter, Okla, since 1933.

Anderson, Charles A, A.B.'12, Williams Col.; M.A.'26, Univ of Pa; D.D.'31, Tusculum Col.; D.D.'34, Williams Col.; Pres., Tusculum Col, Greeneville, Tenn., since 1931.

Anderson, Charles D., B S.'17, Mich. State Col.; M.A.'22, Columbia Univ.; Asst. State Commr. of Educ., Trenton, N. J., since 1934.

Anderson, Earl William, A.B.'18, Univ. of Ill.; A.M '25, Ph.D.'26, Tchrs. Col, Columbia Univ; Prof. of Educ., Bureau of Educ. Research and Dept. of Educ, Ohio State Univ., Columbus, Ohio.

Anderson, Ernest B., B.A.'09, Gustavus Adolphus Col.; M A.'32, Univ. of Minn.; Supt. of Sch, Cloquet, Minn., since 1923.

Anderson, Esther L., B.S.'33, State Tchrs Col, Pittsburg, Kansas; State Supt. of Pub. Instr., Cheyenne, Wyo., since 1939.

Anderson, Mrs. Florence, 2153 Trenton Dr., Trenton, Mich.

Anderson, Hal, B.S.'10, Miss. State Col; Supt. of Sch., Corinth, Miss, since 1930.

Anderson, Harry D., LL.B.'22, Univ of Ill.; B.Ed.'25, Western Ill. State Tchrs Col., Macomb, Ill.; M.A.'31, Univ. of Ill.; Prin., Twp. H. S., Ottawa, Ill., since 1931.

Anderson, Homer W., B.A.'10, Highland Park Col.; M.A.'15, Ph.D.'25, State Univ. of Iowa; Supt. of Sch., 911 Locust St., St. Louis, Mo., since 1940.

Anderson, Howard R., B.A.'22, Augustana Col.; M.A.'28, Univ. of Chicago; Ph.D.'30, State Univ. of Iowa; Assoc. Prof. of Educ., Cornell Univ. and Dir., Social Studies, Pub. Sch., Ithaca, N. Y., since 1937.

Anderson, Hulon N., A.B.'18, M.A.'38, Sam Houston, State Tchrs. Col, Huntsville, Texas; Dist. Supt. of Sch, Conroe, Texas, since 1905.

Anderson, J. E., B.A. in Ed.'11, Univ. of Minn.; Supt. of Sch., Mankato, Minn., since 1931.

Anderson, J. L., A.B.'21, Mich. State Normal Col., Ypsilanti, Mich.; Supt. of Sch, Trenton, Mich., since 1914.

Anderson, James T., A.B.'16, Nebr. Wesleyan Univ.; A.M.'27, Univ. of Nebr; Ed.D.'33, Univ. of Southern Calif., Pres., Nebr. State Tchrs. Col., Wayne, Nebr., since 1935.

Anderson, John Dickson, A.B.'16, Univ. of Rochester; M.A.'30, Ph.D '41, Univ. of Pittsburgh; Prin., H. S., Butler, Pa., since 1937.

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Anderson, Ward, B.A.'23, La. State Univ.; Supt of Sch., Lake Charles, La., since 1920

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Bratcher, E. E., A.B.'19, M.A.'27, Univ. of Ky.; Ph.D.'36, Univ. of Chicago; Supt. of Sch., Hot Springs, Ark., since 1940.

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Burt, C. Vinton, B S '28, Jamestown Col.; M.A.'31, Columbia Univ.; Supt of Sch., Owatonna, Minn., since 1941.

Burton, Hubert C., B.S '14, Univ. of Utah; Dist. Supt. of Sch , Farmington, Utah, since 1908.

Burton, R. H., B S.'27, Central State Tchrs. Col , Edmond, Okla., M.S.'32, Okla. Agrl. and Mech Col., Supt. of Sch., Idabel, Okla., since 1935.

Burtscher, Theresa, Vice-Prin., Longfellow Jr. H. S., Richmond, Calif.

Burtsfield, Frank A., A.B.'08, Ind Univ ; Supt. of Sch , West Lafayette, Ind., since 1912.

Burtt, Jerome, Ph.B.'14, Yale Univ.; A.M.'20, Tchrs Col., Columbia Univ.; Prin., Williams Memorial Inst , New London, Conn., since 1938

Bush, C. H., Supt. of Sch., Sebewaing, Mich.

Bush, Clinton V., Supt. of Sch., Jamestown, N. Y., since 1938

Bush, Mrs Louise P., Supt., Lockport City Sch., Lockport, Ill., since 1930.

Bush, Maybell G , Ph.M.'28, Univ. of Wis.; Supvr. of Elem. Sch., State Dept. of Pub. Instr , 522 N Pinckney St , Madison, Wis , since 1917.

Bushman, W. W , Prin , Sunset H. S., Dallas, Texas.

Bussewitz, Walter R., B.A.'14, M.A.'17, Univ. of Wis., Supt. of Sch., Horicon, Wis., since 1917.

Bussey, E D , B.S '13, Agrl and Mech. Col. of Texas; B.A.'23, East Texas State Tchrs. Col , Commerce, Texas; Supt. of Sch., Garland, Texas, since 1923.

Bustard, Joseph L., B S.'30, Rutgers Univ.; M A.'33, Tchrs. Col., Columbia Univ.; Supvg Prin. of Sch., Roselle, N. J , since 1937.

Buster, N. E , A.B.'25, M.A.'29, Colo. State Tchrs Col , Greeley, Colo.; Prin., Arlington Hgts. H. S., Fort Worth, Texas, since 1934.

Butler, John H. Manning, A.M.'96, Pd D.'24, Livingstone Col ; Dean, Col. of Educ. and Head, Graduate Dept., Union Col of Manila, Manila, P. I., since 1940.

Butler, Leslie A., Ph.B.'13, Univ. of Chicago; M.A.'19, Columbia Univ.; M Ed '21, Mich. State Normal Col., Ypsilanti, Mich ; LL D.'27, Alma Col.; Dir of Laboratory Schs. and Placement, Mich. State Normal Col., Ypsilanti, Mich., since 1939.

Butler, Rock L., B.S.'23, Grove City Col.; M.S.'37, Bucknell Univ ; Supvg. Prin. of Sch., Wellsboro, Pa., since 1914.

Butterworth, Julian E., A.B.'07, M A.'10, Ph.D.'12, State Univ. of Iowa; Prof. of Rural Educ , since 1919 and Dir., Sch. of Educ., Cornell Univ., Ithaca, N. Y., since 1931.

Butts, Louis Andrew, B.S.'16, McKendree Col.; M A.'31, Washington Univ.; Supvr., Elem. and Jr. H S., Belleville, Ill., since 1926.

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Buzzard, Robert Guy, Diploma '14, Ill. State Normal Univ., Normal, Ill.; S.B.'16, S.M.'17, Univ. of Chicago; Ph.D.'25, Clark Univ.; A.M.'38, Univ. of Ill., Pres , Eastern Ill. State Tchrs. Col., Charleston, Ill., since 1933.

Bye, Morris, B A '18, Concordia Col.; M.A. '40, Univ. of Minn.; Supt. of Sch , Thief River Falls, Minn., since 1926

Byerley, J. Roy, M.S.'30, Univ. of Ill ; Asst. State Supt of Pub. Instr. and Dir. of Educ. of Exceptional Children, Springfield, Ill , since 1935.

Byerly, C. C., A.B.'18, Manchester Col.; M.A.'34, Univ. of Chicago; Supt. of Sch., 210 Sophia St., West Chicago, Ill., since 1923.

Byers, B. H., B.S.'20, B.A.'23, M.S.'29, Pa. State Col.; Supvg. Prin. of Sch., Elizabeth, Pa., since 1929

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Bynum, Charles Hudson, A.B.'27, Lincoln Univ.; A.M.'29, Univ. of Pa.; Dean and Chmn , Div. of Educ. and Tchr. Tr., Texas Col., Tyler, Texas, since 1939.

Byrd, H. C., B S in C.E.'08, Univ. of Md.; LL.D.'36, Washington Col.; LL.D '37, Dickinson Col.; D Sc.'37, Western Md. Col.; Pres., Univ. of Md., College Park, Md., since 1935.

Byrd, Rawls, A B.'18, Col. of William and Mary; M.A.'25, Columbia Univ.; Supt. of Sch., Williamsburg, Va., since 1928.

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Cadwell, Vern L., A.B.'23, Univ. of S. Dak ; M A.'36, Colo. Col. of Educ , Greeley, Colo.; Supt. of Sch., Vermillion, S. Dak., since 1941.

Calder, Jessie, Prin., Manzanita Elem. Sch., Oakland, Calif.

Caldwell, A. B., A.B.'16, Maryville Col.; M A '21, Ed.D.'36, Tchrs. Col., Columbia Univ.; Deputy State Commr. of Educ., St. Paul, Minn., since 1936.

Caldwell, Lee L., A.B., Simpson Col.; B.A., Iowa State Tchrs. Col., Cedar Falls, Iowa, Supt. of Sch., Hammond, Ind., since 1922.

Caldwell, Otis W., B.S.'94, Franklin Col.; Ph.D '98, Univ. of Chicago; LL.D.'18, Franklin Col.; Genl. Secy., American Assn. for the Advancement of Science, Yonkers, N. Y. Address: New Milford, Conn.

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Calhoun, Paul W., Co. Supt. of Sch , Mt Vernon, Ga.

Calhoun, Sanford Henry, B.S.'26, St. Lawrence Univ.; M A.'31, Columbia Univ.; Supvg. Prin., Wellington C. Mepham H. S., Bellmore, N. Y., since 1935.

Callaghan, Aloysius R., B.S. in Ed.'31, State Tchrs. Col., Kutztown, Pa.; Supvg. Prin. of Twp. Sch., Pottsville, Pa., since 1936.

Callahan, John, LL.D.'34, Carroll Col., State Supt. of Pub. Instr., State Capitol, Madison, Wis, since 1921

Calloway, Andrew H, B.A.'29, M.A.'41, Ohio State Univ.; Asst. Co. Supt. of Sch., Charleston, W. Va., since 1933.

Cameron, Christina B., Asst. Supt. of Sch., Richmond, Calif., since 1928.

Cameron, James W., M.A '33, Univ. of Pittsburgh; Supvg. Prin. of Edgeworth Sch, Sewickley, Pa., since 1929.

Camp, Harold L, B A.'14, Grinnell Col.; M.A '17, Cornell Univ.; Ph D.'21, State Univ. of Iowa; Prof. of Educ., State Tchrs. Col., Indiana, Pa., since 1930.

Campbell, A. B., B.S.'23, M.A.'33, Univ. of Calif., Asst. Supt. of Sch., 1414 Walnut St., Berkeley, Calif., since 1938.

Campbell, C. G, Adrian, Mich.

Campbell, Doak S., B.A.'11, Ouachita Col.; M A.'28, Ph D.'30, George Peabody Col. for Tchrs.; Pres, Fla. State Col. for Women, Tallahassee, Fla., since 1941.

Campbell, Ernest W., A.B.'18, LL.B.'22, Univ. of Wash.; Asst Supt. of Sch, 810 Dexter Ave., Seattle, Wash, since 1940.

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Campbell, Harold L, B A.'28, Univ. of British Columbia; M.Ed.'38, Univ. of Wash; Municipal Inspector of Schs, City Hall, Victoria, B. C., Canada, since 1936.

Campbell, John Lucas, B S.'15, Southwest Mo. State Tchrs. Col., Springfield, Mo.; A.M '30, Univ. of Mo.; Supt. of Sch, Carthage, Mo, since 1929

Campbell, O. K., A.B.'28, Southeastern State Tchrs. Col., Durant, Okla.; M.A.'35, Tchrs. Col., Columbia Univ.; Asst Prof. of Educ., Okla. Agrl. and Mech. Col., Stillwater, Okla, since 1939.

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Campbell, W. M, Ph B '16, Parsons Col.; Ed.M '34, Univ. of Oregon; Supt. of Sch., Roseburg, Oregon, since 1927.

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Capen, Samuel Paul, A.B. and M.A.'98, Tufts Col, A.M.'00, Harvard Univ.; Ph.D.'02, Univ. of Pa, LL.D '20, Lafayette Col.; L.H.D.'21, Tufts Col.; L.H.D. '25, Hobart Col.; Sc D.'27, George Washington Univ.; LL.D.'32, Univ. of Chicago; LL.D.'33, Univ of Pa.; Litt.D '37, Clark Univ.; LL D '38, McMaster Univ; Chancellor, Univ. of Buffalo, Buffalo, N. Y., since 1922.

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Carlson, Herman E., Prin., Wash. Jr. H. S., Fresno, Calif

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Carothers, Milton W., A B.'19, Univ. of Ala, A M.'27, Tchrs. Col., Columbia Univ.; State Dir of Instr., Tallahassee, Fla, since 1937.

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Carr, John Wesley, A.B.'85, A.M.'90, Ind. Univ, Ph.D.'13, New York Univ; Pres., Dept. of Superintendence, 1905-06. Honorary Life Member, American Assn. of Sch. Admin. Address; State Tchrs. Col., Murray, Ky.

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Carroll, Charles F., A.B.'21, M Ed '30, Duke Univ., Supt. of Sch., High Point, N. C., since 1937.

Carroll, George C., Supt. of Sch., Terre Haute, Ind.

Carroll, Howard S., B.Sc. in Ed.'23, Miami Univ.; M.A.'29, Ohio State Univ.; Supt. of Sch., New Philadelphia, Ohio, since 1933.

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Carrothers, George E., B.A.'09, Ind. Univ.; M.A '15, Tchrs. Col., Columbia Univ.; Ph D.'24, Columbia Univ.; Dir., Bureau of Cooperation with Educ. Inst. and Prof. of Educ., Univ. of Mich., Ann Arbor, Mich., since 1928.

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Carter, C. D., Supt. of Sch., Torrington, Wyo., since 1934.

Carter, David V., A.B.'17, Univ. of N. C.; Co. Supt. of Sch., Clinton, N. C., since 1927.

Carter, E. Frank, B.S.'33, State Tchrs. Col., California, Pa.; M.A. in Ed.'37, Univ. of Pittsburgh; Supt. of Twp. Sch., Belle Vernon, Pa., since 1938.

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Carter, J. Frank, B.S.'17, Aurora Col.; M.A.'23, Univ. of Maine; Ed.D.'31, Temple Univ.; Supt. of Twp. Sch., Llanerch, Upper Darby, Pa., since 1930

Carter, William H., A.B.'10, Middlebury Col.; Supt. of Sch., Barre, Vt., since 1935.

Case, R. D., A.B.'22, M.A.'23, Univ. of Denver; Ed.D.'31, Stanford Univ.; Supt. of Sch., Salinas, Calif., since 1931.

Casey, Charles Clinton, A.B.'04, Ark. Conference Col.; A.M.'06, LL.D.'34, Univ of Denver; Pres., Western State Col., Gunnison, Colo., since 1930.

Casey, John C., B.S.'08, Ark. Col.; M.A.'09, Univ. of Denver; Supt. of Sch., Eaton, Colo., since 1922

Cassel, Lloyd S., A.B.'13, Ursinus Col.; M.A.'28, Columbia Univ.; Supt. of Sch., Freehold, N. J., since 1929.

Cassell, George F., Asst. Supt. of Sch., 228 N. La Salle St., Chicago, Ill., since 1936

Cassidy, Rosalind, B.A.'18, Mills Col.; M.A.'23, Ed.D.'37, Tchrs. Col., Columbia Univ.; Convenor, Sch. of Educ., Mills Col., Oakland, Calif., since 1939.

Cassler, George W., B.S.'20, Susquehanna Univ.; M.S. in Ed.'31, Pa. State Col.; Supvg. Prin. of Sch., Coraopolis, Pa., since 1938.

Caswell, Hollis L., Ph.D.'29, Columbia Univ.; Prof of Educ. and Dir., Div of Instr., Tchrs. Col., Columbia Univ., New York, N. Y., since 1937.

Caswell, Inez E., A.B.'22, Univ of Mich.; Dist. Prin., MacCulloch Sch., 13120 Wildemere, Detroit, Mich., since 1920.

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Cavanaugh, James Franklin, Ph.B.'30, Ph.M.'32, Univ. of Wis.; Supt. of Sch., Kaukauna, Wis., since 1925.

Caverly, Ernest R., A.B.'15, Harvard Univ.; A.M.'27, Columbia Univ.; Supt. of Sch., Town Hall, Brookline, Mass., since 1931.

Cavness, Raymond M., B.A.'25, Southwest Texas State Tchrs. Col., San Marcos, Texas; M.A.'30, Univ. of Texas; Pres., San Marcos Academy, San Marcos, Texas, since 1931.

Cayer, L. A., B.A.'25, La. Col.; Parish Supt. of Sch., Marksville, La., since 1937.

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Center, Leslie R., M.A.'30, Tchrs. Col., Columbia Univ.; Prin., James S. Hogg Jr. H. S., Houston, Texas, since 1937

Center, Stella Stewart, A.B.'01, George Peabody Col. for Tchrs.; Ph.B.'11, Univ. of Chicago; A.M.'13, Columbia Univ.; Litt.D.'29, Univ. of Ga.; Dir., Reading Clinic, New York Univ., New York, N. Y., since 1935.

Chaffee, Charles E., B.S.'27, Susquehanna Univ.; A.M.'31, Bucknell Univ.; Ed.D.'39, New York Univ., Supvg. Prin. of Sch., Downingtown, Pa., since 1937.

Chamberlain, Arthur H., B.S.'03, A.M.'04, Columbia Univ.; Pres. and Editorial Dir., *Overland Monthly and Out West Magazine* and Secy., Calif. Assn. for Education in Thrift and Conservation, Olympic Hotel, San Francisco, Calif., since 1927.

Chambers, H. H., M.A.'27, Univ of Texas; Supt. of Sch., Greenville, Texas, since 1938.

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Chambré, Melda W., B.S. in Ed.'32, M.S.'41, Rutgers Univ., Rural Sch. Supvr., Court House, Flemington, N. J., since 1930.

Champlin, Carroll D., A.B.'14, A.M.'15, Haverford Col.; Ph.D.'25, Univ. of Pittsburgh; Prof of Educ., Pa. State Col., State College, Pa., since 1926.

Chandler, H. E., A.B.'11, Washburn Col.; A.M.'27, Tchrs. Col., Columbia Univ., Assoc. Prof. of Educ. and Dir. of Tchrs. Appointment Bureau, Univ of Kansas, Lawrence, Kansas, since 1934.

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Chapelle, Ernest H., A.M.'25, Univ. of Mich.; Supt. of Sch., Ypsilanti, Mich., since 1934.

Chapman, Ernest T., Diploma '11, Ashland Col.; B.S.'26, Univ. of Pittsburgh; Supt. of Sch., New Kensington, Pa., since 1924.

Chapman, Harold Benjamin, B.A.'11, Yale Univ.; M.A.'24, Tchrs. Col., Columbia Univ.; Ph.D.'26, Ohio State Univ.; Asst. Dir., Bureau of Research and Statistics, Sch. Admin. Bldg., 3 E. 25th St., Baltimore, Md., since 1926.

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Chase, Lawrence S., B S.'09, Colgate Univ.; A.M.'16, Columbia Univ.; Co. Supt. of Sch., Hall of Records, Newark, N. J., since 1933.

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Chenoweth, Arthur S., B.A.'06, Univ. of Colo.; M A. (Oxon.); Supt. of Sch., Atlantic City, N. J., since 1931.

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Chidester, Albert J., A.B.'05, Syracuse Univ.; A.M.'12, Harvard Univ.; Head, Dept. of Educ., Berea Col., Berea, Ky., since 1922

Childs, James R., A.B.'03, Amherst Col.; Supt. of Sch., Holden, Mass., since 1916.

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Chute, Oscar M., B.S.'29, Colby Col.; Ed.M.'34, Harvard Univ.; Dir., Tchr. Tr Dept., Northern Ill. State Tchrs. Col., DeKalb, Ill., since 1941.

Cisne, W. G., M.A.'32, Univ. of Chicago; Supt. of Elem Tr., Southern Ill. State Normal Univ., Carbondale, Ill, since 1935.

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Climenhaga, A. W., A.B.'19, Taylor Univ.; M.A. in Ed.'39, Wittenberg Col.; Dean, Registrar, and Tchr, of Educ., Messiah Bible Col., Grantham, Pa., since 1928.

Cline, Earl D., B S.'16, Drake Univ.; M A.'22, State Univ. of Iowa; Supt. of Sch., Colorado Springs, Colo., since 1940.

Clish, Herbert C., B S.'26, M.A.'27, Ed.D.'40, Columbia Univ.; Supt. of Sch., New Rochelle, N. Y., since 1940.

Cloud, Archibald J., B.L.'00, Univ. of Calif.; LL.D., St. Mary's Col.; Pres., San Francisco Jr. Col., San Francisco, Calif., since 1935.

Cloud, Roy Walter, A.B.'05, Stanford Univ.; Exec. Secy., Calif, Tchrs, Assn., 155 Sansome St., San Francisco, Calif, since 1927.

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Clow, Arlington Ingalls, A.B.'05, Dartmouth Col., Ed.M.'26, Harvard Univ.; Supt. of Sch., Haverhill, Mass., since 1935.

Coale, Elda Mills, Genl. Supvr. and Asst. Co. Supt. of Sch., Oroville, Calif.

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Cody, Frank, M Pd.'12, Mich. State Normal Col., Ypsilanti, Mich.; M.A.'24, Univ. of Mich.; LL.D.'33, Univ. of Detroit, Pres., Dept. of Superintendence 1929-30; Pres., Wayne Univ., Detroit, Mich., since 1933 and Supt. of Sch., 1354 Broadway, Detroit, Mich., since 1919.

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Coleman, Maurice L., B.S. in Ed'29, M.A. in Ed.'30, Ed.D.'38, Univ. of Mo.; Supt. of Sch., Asbury Park, N. J., since 1940.

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Collins, Orvis K., A.B.'02, Middlebury Col; Supt. of Sch., Hingham, Mass., since 1916.

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Combs, A. B., B.A.'10, M.A.'11, Wake Forest Col.; Assoc., Div. of Instructional Serv., State Dept. of Pub. Instr., Raleigh, N. C., since 1929.

Combs, Morgan LaFayette, A.B.'17, Univ. of Richmond; A.M.'22, Univ. of Chicago; Ed.M.'26, Ed.D.'27, Harvard Univ.; Pres., Mary Washington Col., Fredericksburg, Va., since 1928

Compton, John L., A.B.'24, Whittier Col.; M.A.'29, Univ. of Southern Calif.; Supt. of Sch., Bakersfield, Calif., since 1940.

Compton, Lillian C., B.A.'16, Univ. of W. Va.; M.A.'30, Tchrs. Col., Columbia Univ.; Asst. Supt. of Sch., Cumberland, Md., since 1919.

Comstock, Ernest Bernard, A.B.'05, Oberlin Col.; M.A.'26, Univ. of Chicago; Prin., North Dallas H. S., Dallas, Texas, since 1922.

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Cook, Albert S., A.B.'95, A.M.'06, Princeton Univ.; Litt.D.'23, Western Md Col.; Litt.D.'23, St. John's Col., Annapolis, Md.; Litt.D.'24, Univ. of Md.; LL.D.'37, Gettysburg Col.; State Supt. of Sch., Baltimore, Md., since 1920.

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Cook, Hugh Oliver, B.A.'99, M.A.'25, Cornell Univ.; Prin., Lincoln H. S., Kansas City, Mo., since 1923.

Cook, Mrs. Katherine M., A.M.'12, Columbia Univ.; Chief, Div. of Special Problems, U S. Office of Educ, Washington, D. C., since 1921.

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Cooper, Shirley, A.B.'35, Davis and Elkins Col.; A M.'40, W. Va. Univ.; Co. Supt. of Sch., Parsons, W. Va., since 1935.

Cope, Earl R., Supt. of Sch., Jesup, Iowa.

Copeland, Richard Watson, B.S.'20, M.A.'40, Col of William and Mary; City and Co. Supt. of Sch., Hopewell, Va., since 1929

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Cory, Frank Mirl, A.B.'17, Ind. Univ.; A.M.'23, Tchrs. Col., Columbia Univ.; Supt. of Sch., Hagerstown, Ind., since 1926.

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Couey, Fred, A.B.'29, Colo. Col., M.A.'32, Colo. Col. of Educ., Greeley, Colo., Ph.D.'38, Univ. of Wash.; Assoc. Prof. of Educ., Univ. of Conn., Storrs, Conn., since 1939.

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Crackel, Verne E., B.A.'37, M.A.'40, Univ. of Chicago, Supt. of Sch., Crete, Ill., since 1927.

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Cramer, William Floyd, B.S.'17, Univ. of Mo.; M.S.'26, Univ. of Kansas; Dean, Sch. of Arts and Sciences, Central YMCA Col., 19 S. La Salle St., Chicago, Ill., since 1936.

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Cummings, L. O., A.B.'10, A.M.'11, Ed.D.'21, Harvard Univ.; Dean, Sch. of Educ, Univ. of Buffalo, Buffalo, N. Y., since 1931.

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Hasty, S. G , B A '03, Wake Forest Col ; M.A.'15, Columbia Univ.; Co. Supt. of Sch., Salisbury, N. C., since 1930.

Hatch, H. T , A B '22, Western State Col., Gunnison, Colo.; M.A.'30, Univ of Calif., Supt. of Sch., Gunnison, Colo., since 1934.

Hatfield, Carson A., Ph B.'26, Ph.M.'35, Univ. of Wis.; Supt. of Sch., Park Falls, Wis , since 1935.

Hatfield, Gertrude M., Prin., A. A. Hyde Elem. Sch., Wichita, Kansas.

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Hawkes, Charles E., B.S.'27, Fort Hays State Col , Hays, Kansas; M.A '37, Tchrs Col , Columbia Univ.; Supt. of Sch., Salina, Kansas, since 1938.

Hawkes, Franklin Powers, A.B '17, Amherst Col.; A.M.'21, Ph.D.'27, Boston Univ.; Supt. of Sch., West Springfield, Mass., since 1940.

Hawkins, Earle T., B A.'23, Western Md. Col.; M.A.'28, Columbia Univ.; State Supvr. of H. S., Lexington Bldg., Baltimore, Md., since 1938.

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Hunt, Herold C., A.B.'23, A.M.'27, Univ. of Mich.; Ed.D.'40, Tchrs. Col., Columbia Univ.; Supt. of Sch., Kansas City, Mo., since 1940.

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McGaughy, James Ralph, A.B '12, Park Col., M.A.'21, Ph.D '24, Columbia Univ.; Prof. Emeritus of Educ., Tchrs. Col, Columbia Univ, New York, N. Y., since 1941.

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McGucken, William J., B.A.'09, Marquette Univ.; M.A.'17, St. Louis Univ.; Ph.D.'27, Univ of Chicago; Dir., Dept. of Educ. and Regional Dir of Studies in Col. and H. S. of Mo. Province, St Louis Univ., St. Louis, Mo, since 1935.

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McInerney, Mrs. Isabel, M A '33, Natl. Univ of Mexico; Co. Sch. Advisor and Supt. of Town Schs, Las Vegas, N. Mex, since 1940.

McIntosh, Daniel C., A B.'13, A M '16, Ind Univ.; B S.'20, Iowa State Col.; Ph D.'24, Ind. Univ.; Dean. Grad Sch. and Head, Dept. of Agrl. Educ., Okla. Agrl. and Mech. Col, Stillwater, Okla., since 1928

McIntosh, William Ray, B S.'20, M.A.'23 Northwestern Univ; M S.'32, Univ of Ill.; Supt., Twp. H. S, Olney, Ill., since 1931.

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McKibben, J. D, B.S '28, Univ. of Chicago, M S.'40, Univ. of Ill.; Supt. of Sch, Clinton, Ill., since 1940.

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McLaughlin, Sister Mary Aquinas, B A.'17, Catholic Univ. of America; M.A.'22, Notre Dame Univ., Ph D '30, State Univ of Iowa; Dean, Briar Cliff Col, Sioux City, Iowa, since 1930.

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McLure, John Rankin, B.S '11, Univ. of Ala.; M A.'14, Ph.D.'25, Columbia Univ., LL D.'30, Univ of Ala.; Prof. of Sch. Admin and Head, Dept. of Sch. Admin., Univ. of Ala., University, Ala., since 1924.

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McMullen, J. Willard, A.B.'21, Univ of Del.; M.A.'35, Univ. of Pa.; Supvg. Prin. of Sch, Oxford, Pa., since 1923.

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Mann, Mrs. Margaret, Co. Supt. of Sch., Primghar, Iowa, since 1926.

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Martin, J. A., B.S.'18, Pa. State Col.; M.A. '36, Tchrs. Col , Columbia Univ.; Supvg. Prin of Sch., Trucksville, Pa., since 1932.

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Mason, Charles C., A.B.'25, Central Wesleyan Col.; A.M.'28, Wash. Univ.; D Ed. '41, Colo. State Col of Educ , Greeley, Colo ; Asst Supt. of Sch., 410 S. Cincinnati, Tulsa, Okla., since 1935.

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Matzen, John M., A.B.'27, A.M.'28, Tchrs Col., Univ. of Nebr.; A.M.'29, Ph.D.'31, Tchrs. Col., Columbia Univ.; Asst. Prof of Sch. Admin., Tchrs. Col., Univ. of Nebr , Lincoln, Nebr., since 1931.

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Smith, O. E., Exec. Secy., State H. S League, Anoka, Minn., since 1928

Smith, P. O., B.A.'40, Texas Tech. Col ; Supt. of Sch., Whiteface, Texas, since 1936.

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Smith, Ralph R., Diploma '15, State Tchrs Col., Millersville, Pa.; B.S. in Ed.'24, M.A.'27, Univ. of Pa.; Supt. of Sch , Lansdale, Pa., since 1926.

Smith, Raymond A., A.B.'00, A.M '04, Butler Col.; B.D.'05, Yale Univ.; Dir., Sch. of Educ., Texas Christian Univ., Ft. Worth, Texas, since 1920.

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Smith, Sim Joe, A.B.'15, Trinity Univ., LL.B.'21, Univ. of Texas; M.A.'27, Tchrs Col., Columbia Univ.; Asst. Supt. of Sch., New Rochelle, N. Y , since 1930.

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Snapp, C. V., A.B '23, M.A.'34, Univ. of Ky.; Supt. of Sch., Jenkins, Ky., since 1929.

Snead, Joseph Payne, Co. Supt of Sch., Fork Union, Va.

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Sorensen, R. R., B S.'15, Carleton Col., A M.'24, Columbia Univ.; Supt. of Sch., Tracy, Minn., since 1921.

Sorensen, Raymond J., Co. Supt. of Sch., Hammond, Wis , since 1930.

Sorenson, Herbert, Ph.D.'28, Univ of Minn., Pres., Duluth State Col., Duluth, Minn , since 1938.

Sotzin, Heber Allen, A.B.'23, M A.'26, George Wash. Univ.; Ph D.'29, Univ. of Cincinnati; Prof. of Educ. and Dir. of Indus. Arts, San Jose State Col., San Jose, Calif., since 1929

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Spalding, Willard, B.B.A.'26, Boston Univ , Ed.M.'33, Univ. of N. H.; Supt. of Sch , Passaic, N. J., since 1941.

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Wenger, Paul, B.A.'25, Bluffton Col , M.A. '30, Ohio State Univ.; Supt. of Sch , Lancaster, Ohio, since 1938.

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West, Glen C., B.S. in Ed '17, Ohio Univ.; M A.'28, Columbia Univ.; Co. Supt. of Sch , Bucyrus, Ohio, since 1937.

West, Guy A., M.A.'28, Univ. of Colo.; Ed D.'31, Univ. of Calif ; Prof. of Educ. and Dir. of Research, Chico State Col., Chico, Calif., since 1933.

West, Henry S., A.B.'93, Ph.D.'99, Johns Hopkins Univ.; Dean and Prof. of Educ., Univ. of Miami, Coral Gables, Fla., since 1926.

West, Parl, A.B.'21, Univ. of Nebr.; A.M. '28, Ph.D.'33, Tchrs. Col., Columbia Univ., Prin., Sch of Practice, State Normal Sch., Potsdam, N. Y., since 1934.

West, Paul Douglass, Ph.B.'24, Emory Univ.; M.A '25, Oglethorpe Univ.; M.A '40, Emory Univ.; Prin., Russell H. S., East Point, Ga., since 1932.

West, Roscoe L., A.B '14, Ed.M.'23, Harvard Univ.; Pres , State Tchrs. Col., Trenton, N J., since 1930.

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